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The Perplexities of Age and Power

Sharona Hoffman

Case Western University School of Law, sharona.hoffman@case.edu

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THE PERPLEXITIES OF AGE AND POWER

Sharon Hoffman

The elderly population in the United States is growing dramatically and is expected to reach over seventy-two million, or 20% of the citizenry, by 2030. But serious legislative and regulatory gaps leave the surging population of older adults with many unmet needs. Many Americans are aware of the Social Security and Medicare funds' financial woes. This Article emphasizes that these challenges are only the tip of the iceberg. In addition, the elderly face under-funded Older Americans Act programs, unaffordable long-term care, inadequate driving regulations that fail to identify and protect at-risk drivers, and a significant shortage of geriatricians, among other problems.

Neglect of the aging population in the legal and policy arenas makes little sense. Public choice theory, which teaches that all political actors act in their own self-interest, would suggest that support for the elderly should be a high priority because all individuals face the prospect of aging and caring for elderly loved ones. Relying in part on this theory, this Article develops new insights as to why seniors fail to use their potential political strength to advocate forcefully for beneficial policy changes and why aging issues do not resonate with policymakers, voters, or the media. This Article argues that it is human nature to avoid contemplating one's future decline, and thus we choose to ignore the challenges that lie ahead. Elected officials, in turn, respond to voters' priorities and conclude that focusing on eldercare matters will not win them votes or yield political pay-offs. The media, for their part, prefer sensational stories to those that

Sharon Hoffman is the Edgar A. Hahn Professor of Law and Professor of Bioethics, Co-Director of Law-Medicine Center, Case Western Reserve University School of Law; B.A., Wellesley College; J.D., Harvard Law School; LL.M. in Health Law, University of Houston; S.J.D. in health law, Case Western Reserve University School of Law. Author of *AGING WITH A PLAN: HOW A LITTLE THOUGHT TODAY CAN VASTLY IMPROVE YOUR TOMORROW* (Praeger 2015).

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engage in deep exploration of social problems' causes and solutions.

At its core, the Article is a call to action, as highlighted in its recommendations section. Aging and caregiving for elderly loved ones are not special-interest matters but matters that will affect all of us. Preparing for the swelling older population is not only in everyone's best interest, but is also a regulatory, social, and political necessity.

INTRODUCTION

It is no secret that the elderly constitute a growing segment of the population in the United States. According to government statistics, in 2015, 14.9% of the population, or 47.8 million people, were sixty-five and older.¹ The sixty-five and older population is projected to expand to 72.7 million by 2030 and to represent over 20% of total U.S. residents.² This dramatic population growth will be attributable to the "baby boomers," individuals born between 1946 and 1964, who began turning sixty-five in 2011.³ Those who are eighty-five years old and older numbered 5.9 million in 2012.⁴ Experts predict that by 2060, the eighty-five and older population will swell to 19.7 million.⁵

Older adults have many pressing needs that the American legal, health care, social services, and other systems fail to meet.⁶ These needs will only grow as the elderly population expands. Two significant matters that have received media attention are the dramatic rise in drug prices and the potential insolvency of the Social Security and Medicare funds.⁷ The law cannot remedy all of the problems that American seniors face, but there is an increasingly urgent need to implement appropriate regulatory and statutory interventions. This Article, in large part,

1. FFF: *Older Americans Month: May 2017*, U.S. CENSUS BUREAU (Apr. 10, 2017), <https://www.census.gov/newsroom/facts-for-features/2017/cb17-ff08.html> [hereinafter U.S. CENSUS BUREAU].

2. Jennifer M. Ortman et al., *An Aging Nation: The Older Population in the United States: Population Estimates and Projections* 1, 2-6 (2014), <https://www.census.gov/content/dam/Census/library/publications/2014/demo/p25-1140.pdf>.

3. *Id.* at 1.

4. *Id.*

5. U.S. CENSUS BUREAU, *supra* note 1.

6. See generally SHARONA HOFFMAN, *AGING WITH A PLAN: HOW A LITTLE THOUGHT TODAY CAN VASTLY IMPROVE YOUR TOMORROW* (2015) [hereinafter S. HOFFMAN].

7. Katie Thomas, *Drug Prices Keep Rising Despite Intense Criticism*, N.Y. TIMES (Apr. 26, 2016), http://www.nytimes.com/2016/04/27/business/drug-prices-keep-rising-despite-intense-criticism.html?_r=0; Nick Timiraos, *Social Security, Medicare Face Insolvency Over 20 Years, Trustees Report*, WALL ST. J. (June 22, 2016), <http://www.wsj.com/articles/social-security-medicare-trust-funds-face-insolvency-over-20-years-trustees-report-1466605893>.

is a call to action. It urges both voters and elected officials to focus on solving the challenge of aging in America with much greater intensity and commitment.

Part I of this Article provides background information on the elderly population's demographics and care needs. Part II highlights several areas of critical need for the elderly population that could be improved through legal interventions.⁸ It emphasizes that the problems are not restricted to the Social Security and Medicare funding shortfalls, of which many Americans are aware. Instead, the challenges are wide-ranging and multi-layered. For example, programs promulgated under the Older Americans Act are significantly under-funded.⁹ Professional long-term care, in the form of in-home aides, assisted living, and nursing homes, is unaffordable for many people.¹⁰ State governments fail to identify and protect elderly motorists who are at risk of unsafe driving.¹¹ In addition, the older population faces a serious shortage of geriatricians who are specially trained to address the elderly's medical problems and coordinate their care.¹² These are only a few of the many serious difficulties that American seniors currently face.

Because of their numbers and the high rate at which they vote,¹³ older citizens potentially have a strong political voice and significant influence. In the 2016 "Brexit" vote, pensioners were largely responsible for deciding that the United Kingdom should leave the European Union.¹⁴ This Article puzzles over why, despite their political power, senior citizens' needs for care and support do not seem to be a national priority in the United States.

Part III of the Article develops answers to this question.¹⁵ First, it explores principles of public choice theory and offers a novel application of this theory to advocacy for the elderly.¹⁶ The theory's central theme is that what motivates political actors, including legislators and

8. See *infra* Part II.

9. See *infra* Part II.A.

10. See *infra* Part II.B.

11. See *infra* Part II.C.

12. See *infra* Part II.D.

13. See U.S. CENSUS BUREAU, *supra* note 1 and accompanying text; see also *infra* notes 193-94 and accompanying text.

14. See Simon Shuster, *The U.K.'s Old Decided for the Young in the Brexit Vote*, TIME (June 24, 2016), <http://time.com/4381878/brexit-generation-gap-older-younger-voters/>.

15. See *infra* Part III.

16. See *infra* Part III.A.

voters, is their self-interest rather than concern for the common good.¹⁷ Thus, legislators pursue initiatives that they believe will most effectively secure votes in future elections.¹⁸

The Article analyzes why politicians do not perceive advocating for the elderly to be politically advantageous. It also assesses the strengths and weaknesses of advocacy organizations, such as the AARP. Second, Part III argues that human beings tend to avoid thinking about their own decline and find it impossible to imagine becoming frail and dependent. This tendency may contribute to the absence of aging matters from the political arena.¹⁹ Finally, Part III evaluates the role of the media.²⁰ It examines how the media portray the challenges that the elderly face and the extent to which the media have agenda-setting powers. It also considers why eldercare matters do not receive more frequent and prominent media coverage. The Article argues that the media prefer sensational stories about immediate crises to those that explore the causes of and solutions to social problems, such as the unmet needs of the elderly.

Part IV outlines several recommendations to address the problems on which this Article focuses. These include interventions to make long-term care and long-term care insurance more affordable, to enhance the job satisfaction of professional caregivers, to improve the efficacy of driving regulations, to incentivize medical students to enter the field of geriatrics, and to educate the public, policymakers, and the media about the challenges of aging in America and the need for political advocacy for the elderly and their caregivers.

As many commentators have observed, the needs of the elderly are not a common topic of conversation in national policy circles.²¹ An article in the *New England Journal of Medicine* noted that Republican presidential candidates often attacked the Affordable Care Act during their 2016 primary campaigns, but no candidate paid serious attention to long-term care challenges.²² The author then laments that “a major

17. See *infra* note 216.

18. *Id.*

19. See *infra* Part III.B.

20. See *infra* Part III.C.

21. See *infra* notes 231–33 and accompanying text.

22. John K. Iglehart, *Future of Long-Term Care and the Expanding Role of Medicaid Managed Care*, 374 N. ENG. J. MED. 182, 186 (2016) (“Although health care issues received considerable attention during 35 Democratic and Republican debates back before the 2008 election, not a single major debate question focused specifically on long-term care.”) [hereinafter Iglehart].

societal challenge looms without a policy roadmap to guide it.”²³ Likewise, Representative Debbie Dingell emphatically states that “[t]o put the nation on a sustainable path, a national conversation needs to be initiated about long-term care in the United States and how to pay for it.”²⁴ This Article aims to help launch such a conversation.

I. Background: Demographics and Care Needs

Does American society need to worry about the welfare of its elderly population? The answer is clearly yes. Americans generally live long past retirement, but all too many do so without adequate financial security, without sufficient assistance from loved ones, and in poor health.²⁵

In 2013, life expectancy in the United States was 81.2 years for women and 76.4 years for men.²⁶ Life expectancy varies with age, among other factors, and thus individuals who have reached the age of sixty-five can expect to live even longer. This is because they have survived infancy, childhood, young adulthood, and the many hazards that people face earlier in life.²⁷ Among those who are now sixty-five, women can expect to reach the age of eighty-four and men age eighty-one.²⁸

As Americans age, their health problems multiply. Approximately 92% of older adults suffer from at least one chronic condition, and 77% have at least two.²⁹ The most common conditions afflicting this population are hypertension, heart disease, diabetes, cancer, stroke, chronic bronchitis, emphysema, asthma, and kidney disease.³⁰

23. *Id.*

24. Rep. Debbie Dingell, *Policy Essay: The Wide Range of Challenges Facing Seniors* 52 HARV. J. ON LEGIS. 309, 325 (2015) [hereinafter Dingell].

25. See *infra* note 258 and accompanying text.

26. Jiaquan Xu et al., *Deaths: Final Data for 2013*, 64 NAT'L VITAL STAT. REP. 1, 6 (Feb. 16, 2016).

27. Maggie Koerth-Baker, *Death of A Caveman: What Swedish Babies and the Stone Age Can Teach Us About Life Expectancy and Income Inequality*, N.Y. TIMES MAGAZINE, March 24, 2013, at 14; see Eileen M. Crimmins et al., EXPLAINING DIVERGENT LEVELS OF LONGEVITY IN HIGH-INCOME COUNTRIES 1–6 (2011). Other factors, such as obesity, smoking, and physical activity, affect longevity as well.

28. Lawrence A. Frolik & Linda S. Whitton, EVERYDAY LAW FOR SENIORS 3 (2012).

29. *Healthy Aging Fact Sheet*, NAT'L COUNCIL ON AGING (2016), <https://www.ncoa.org/resources/fact-sheet-healthy-aging/>.

30. Virginia M. Freid et al., *Multiple Chronic Conditions among Adults Aged 45 and Over: Trends Over the Past 10 Years*, NCHS DATA BRIEF, No. 100 (July 2012), <http://www.cdc.gov/nchs/data/databriefs/db100.pdf>.

Furthermore, in 2016, an estimated 5.4 million Americans suffered from Alzheimer's disease, and all but 200,000 of these were sixty-five and older.³¹ Thus, 11% of individuals sixty-five and older had Alzheimer's disease. The figure is expected to rise to at least 13.8 million by 2050.³² Moreover, Alzheimer's disease is only one form of dementia and accounts for only 60 to 70% of dementia cases.³³ At death, as many as one in three individuals is afflicted with dementia.³⁴

Alzheimer's disease and other dementias were estimated to cost the United States \$236 billion in 2016.³⁵ Much of the burden of caring for this population falls on family and friends. According to the Alzheimer's Association, over 15 million Americans tended to dementia patients in 2016, supplying an estimated 18.1 billion hours of unpaid care.³⁶

Overall, older adults receive 83% of the help they need from unpaid caregivers³⁷ who provide \$470 billion worth of care.³⁸ This means that many younger people, most often middle-aged sons and daughters bear the burden of eldercare while working and raising their own families.

But increasingly, many individuals cannot receive free care from loved ones. Approximately 26% of seniors live alone.³⁹ More specifically, 32% of women and 18% of men who are sixty-five or older live by themselves.⁴⁰ This figure includes as many as 800,000 individuals with Alzheimer's disease.⁴¹ Moreover, many people do not have children. In 2014, 15% of women between the ages of forty and forty-four

31. ALZHEIMER'S ASS'N, 2016 ALZHEIMER'S DISEASE FACTS AND FIGURES 17 (2016), http://www.alz.org/documents_custom/2016-facts-and-figures.pdf [hereinafter ALZHEIMER'S ASS'N].

32. *Id.*

33. *Dementia: Fact Sheet*, WORLD HEALTH ORG., <http://www.who.int/mediacentre/factsheets/fs362/en/> (last visited Sept. 25, 2016).

34. 2017 *Alzheimer's Disease Facts and Figures*, ALZHEIMER'S ASS'N, <http://www.alz.org/facts/> (last visited Sept. 25, 2016).

35. *Id.*

36. ALZHEIMER'S ASS'N, *supra* note 31, at 27.

37. *Id.* at 32.

38. Allison K. Hoffman, *Reimagining the Risk of Long-Term Care*, 16 YALE J. HEALTH POL'Y L. & ETHICS 151, 158 (2016) [hereinafter A. Hoffman].

39. Renee Stepler, *Smaller Share of Women Ages 65 and Older Are Living Alone*, PEW RES. CTR. (Feb. 18, 2016), <http://www.pewsocialtrends.org/2016/02/18/smaller-share-of-women-ages-65-and-older-are-living-alone/>.

40. *Id.*

41. 2012 *Alzheimer's Disease Facts and Figures Released Today*, ALZHEIMER'S ASS'N, http://www.alz.org/documents_custom/public-health/alzheimers-association_public_health_update_march_2012.pdf (last visited Sept. 25, 2016).

had never given birth.⁴² Because children are the most likely source of unpaid care, elderly individuals who are childless are especially likely to have unmet care needs.⁴³

Sadly, many older adults cannot afford to pay for the help they need. In 2014, the yearly median household income of individuals who were sixty-five or older was \$36,895, and in 2011, seniors' median net worth was \$170,516.⁴⁴ Ten percent were living in poverty.⁴⁵ According to a 2015 report issued by the U.S. Government Accountability Office, "[a]bout half of households age fifty-five and older have no retirement savings (such as in a 401(k) plan or an IRA)."⁴⁶ The National Institute on Retirement Security found that American households had a median retirement savings account balance of just \$2,500, and the median for those nearing retirement was a mere \$14,500.⁴⁷ Such meager savings make it extremely difficult for retirees to cover their out-of-pocket medical costs, which often reach several thousands of dollars per year,⁴⁸ to say nothing of long-term care costs, such as nursing homes, assisted living, and in-home care.⁴⁹ Notably, American seniors struggle to pay for their health care to a greater extent than seniors in many other developed countries.⁵⁰ A 2014 Commonwealth Fund study explained

42. Gretchen Livingston, *Childlessness Falls, Family Size Grows Among Highly Educated Women* (May 7, 2015), <http://www.pewsocialtrends.org/2015/05/07/childlessness/>.

43. *Id.*

44. U.S. CENSUS BUREAU, *supra* note 1.

45. *Id.*

46. U.S. GOV'T ACCOUNTABILITY OFF., GAO-15-149, RETIREMENT SECURITY: MOST HOUSEHOLDS APPROACHING RETIREMENT HAVE LOW SAVINGS (2015), <http://www.gao.gov/assets/680/670153.pdf>.

47. Nari Rhee & Ilana Boivie, THE CONTINUING RETIREMENT SAVINGS CRISIS, NAT'L INSTITUTE ON RETIREMENT SEC. 1 (2015), http://www.nirsonline.org/storage/nirs/documents/RSC%202015/final_rsc_2015.pdf [hereinafter Rhee & Boivie].

48. Richard W. Johnson & Corina Mommaerts, URBAN INST., WILL HEALTH CARE COSTS BANKRUPT AGING BOOMERS? 11 (2010), <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412026-Will-Health-Care-Costs-Bankrupt-Aging-Boomers-.PDF> (predicting that seniors' average out-of-pocket annual expenditures for medical care would be \$4,116 in 2020 and \$7,832 in 2040).

49. *See infra* Part II.B.

50. Robin Osborn et al., THE COMMONWEALTH FUND, INTERNATIONAL SURVEY OF OLDER ADULTS FINDS SHORTCOMINGS IN ACCESS, COORDINATION, AND PATIENT-CENTERED CARE (Nov. 19, 2014), <http://www.commonwealthfund.org/publications/in-the-literature/2014/Nov/International-Survey-of-Older-Adults> (surveying 15,000 people age 65 or older in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States, and finding that U.S. seniors "have the most trouble paying medical bills").

that, “[d]espite Medicare coverage, older Americans have less protection from health care costs, primarily because of high deductibles and copayments, especially for pharmaceuticals, and limitations on catastrophic expenses and long-term care coverage.”⁵¹

II. The Inadequacy of Government Programs, Laws, and Regulations

The elderly population in the United States suffers many unmet needs. This Part analyzes several that illustrate their broad range and seriousness: the dearth of funding for Older Americans Act programs, the very high cost of long-term care, weak regulatory efforts to identify and protect at-risk elderly drivers, and the shortage of geriatric medical care. In each of these areas, older adults would benefit greatly from additional regulatory or statutory interventions. This Part also discusses “international human rights” doctrine and notes that it has not elevated protection of the elderly’s rights to the same status as protection of the rights of other vulnerable populations.

A. The Older Americans Act

A key resource for the aging population is the Older Americans Act of 1965 (OAA),⁵² which supports a variety of services. With the help of the Department of Health and Human Services’ Administration on Aging, the law provides for grants that enable state, local, and private agencies to furnish services such as Meals on Wheels, transportation, home care, aid for family caregivers, and disease prevention/health promotion programs.⁵³ But OAA funding has remained flat for almost a decade, even as the elderly population has steadily grown, and in 2016, it totaled only \$1.915 billion.⁵⁴ By comparison, President Trump famously asserted that the cost of a new Air Force One will be over \$4 billion, and the Air Force’s more modest estimate is a five-year cost of

51. *Id.*

52. 42 U.S.C. §§ 3001-3057 (2018), *reauthorized by* the Older Americans Act Reauthorization Act of 2016, Pub. L. No. 114-144 (Apr. 19, 2016).

53. Carol V. O’Shaughnessy, NAT’L HEALTH POL’Y F., OLDER AMERICANS ACT OF 1965: PROGRAMS AND FUNDING 4-8 (2012), http://www.nhpf.org/library/the-basics/Basics_OlderAmericansAct_02-23-12.pdf [hereinafter O’Shaughnessy].

54. Kirsten J. Colello & Angela Napili, CONG. RES. SERV., OLDER AMERICANS ACT: BACKGROUND AND OVERVIEW 5 (2016); Ravi B. Parikh et al., *The Older Americans Act at 50—Community-Based Care in a Value-Driven Era*, 373 NEW ENG. J. MED. 399, 400 (2015), <https://www.fas.org/sgp/crs/misc/R43414.pdf>.

\$2.8 billion.⁵⁵ Because of inadequate funding, a mere 5% of eligible adults (those sixty and older) benefit regularly from OAA-funded programs, and 14% benefit occasionally.⁵⁶ To illustrate the point, if all family caregivers were to seek financial assistance from the National Family Caregiver Support Program, which is funded at approximately \$150 million per year, they would receive just three to ten dollars per person.⁵⁷ In the words of one commentator, “the government safety net for seniors has been fraying for years, victimized by woeful underfunding.”⁵⁸

B. Long-Term Care

Seventy percent of those who are currently approaching the age of sixty-five will require assistance with activities of daily living for, on average, three years.⁵⁹ Many will obtain assistance from loved ones, but others will turn to professional providers. In 2015, over 8.3 million people paid for long term care services.⁶⁰ These services are available from five primary sources: nursing homes, residential care communities such as assisted living, home health agencies, hospice care, and adult day service centers.⁶¹ It is estimated that, by 2050, twenty-seven million individuals will need long-term care.⁶² This increase is attributable both to the growth of the elderly population and to an anticipated decrease

55. *Trump Says Air Force One Costs Are “Out of Control.” By How Much?*, FORTUNE (Dec. 10, 2016), <http://fortune.com/2016/12/10/air-force-one-actual-cost/>.

56. O’Shaughnessy, *supra* note 53, at 5–6.

57. Howard Gleckman, *One Cheer for Congress Renewing The Older Americans Act*, FORBES (Apr. 20, 2016), <http://www.forbes.com/sites/howardgleckman/2016/04/20/one-cheer-for-congress-renewing-the-older-americans-act/#126e89ea477e>.

58. *Id.*

59. Lindsay Goldman & Robert Wolf, MILBANK MEMORIAL FUND, HOW CAN STATES SUPPORT AN AGING POPULATION? ACTIONS POLICYMAKERS CAN TAKE 13 (2016), <http://www.milbank.org/uploads/documents/MMF%20-%20NYAM%20Aging%20Report.pdf> [hereinafter Goldman & Wolf].

60. *Selected Long-Term Care Statistics*, FAMILY CAREGIVER ALL. (Jan. 31, 2015), <https://www.caregiver.org/selected-long-term-care-statistics> [hereinafter FAMILY CAREGIVER ALL.].

61. U.S. DEP’T OF HEALTH AND HUM. SERVS, LONG-TERM CARE SERVICES IN THE UNITED STATES: 2013 OVERVIEW, 37 VITAL & HEALTH STAT. VIII-IX (2013), http://www.cdc.gov/nchs/data/nsltcp/long_term_care_services_2013.pdf (reporting 2012 numbers. There are approximately 15,700 nursing homes; 22,200 residential care communities, such as assisted living; 12,200 home health agencies; 3,700 hospices; and 4,800 adult day service centers.).

62. FAMILY CAREGIVER ALL., *supra* note 60.

in the availability of unpaid caregivers—the latter because the population of those in the forty-five to sixty-four age range will shrink.⁶³

1. LONG-TERM CARE COSTS

Long-term care services are extremely expensive, and patients often must pay for them out-of-pocket.⁶⁴ This Part analyzes the various long-term care alternatives and their costs.

a. Skilled Nursing Facilities and Nursing Homes

Nursing homes are residential institutions that provide assistance with activities of daily living and other health-related services to residents with physical or mental impairments.⁶⁵ Many nursing homes are also certified by Medicare as skilled nursing facilities that provide care by licensed practitioners who are available twenty-four hours a day.⁶⁶ While many patients spend a few weeks or months in nursing homes to recover from surgeries or injuries, some become permanent residents, and they are among the most frail elderly.⁶⁷ Commonly, the patients are there because they have severe dementia, incontinence, behavioral problems, or no family.⁶⁸ Many view nursing homes as a choice of last resort for individuals who cannot live in any other setting, and commentators have often criticized the quality of care and quality of life in these institutions.⁶⁹

Nursing homes provide most of the long-term care that public insurance programs cover. Medicare coverage is available for Medicare-certified nursing facilities, but only to a limited extent.⁷⁰ To be eligible

63. Goldman & Wolf, *supra* note 59, at 13, 18 (predicting that “the unpaid caregiver support ratio [will] decline[] from 7:1 to 4:1”); Iglehart, *supra* note 22, at 184.

64. See S. HOFFMAN, *supra* note 6, at 85–93.

65. Marlo Sollitto, *What’s the Difference Between Skilled Nursing and a Nursing Home?*, AGINGCARE.COM, <https://www.agingcare.com/articles/difference-skilled-nursing-and-nursing-home-153035.htm> (last visited Sept. 25, 2017) [hereinafter Sollitto]; U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., NURSING FACILITIES, Medicaid.gov, <https://www.medicaid.gov/medicaid/ltss/institutional/nursing/index.html> (last visited Feb. 10, 2017) [hereinafter U.S. CTRS. FOR MEDICARE & MEDICAID SERVS.].

66. Sollitto, *supra* note 65; U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 65.

67. Paula Span, *WHEN THE TIME COMES: FAMILIES WITH AGING PARENTS SHARE THEIR STRUGGLES AND SOLUTIONS* 149 (2009) [hereinafter Span].

68. *Id.* at 161.

69. *Id.* at 149; Victoria Shier et al., *What Does the Evidence Really Say About Culture Change in Nursing Homes?* 54 *THE GERONTOLOGIST* S6, S6–S7 (2014).

70. Span, *supra* note 67, at 85–86.

for Medicare coverage, patients must have been transferred to the facility after spending at least three consecutive days as admitted patients in a hospital.⁷¹ Some patients stay in hospitals “under observation,” and observational status does not qualify them for subsequent nursing home coverage.⁷²

Patients who meet Medicare requirements can receive twenty days of free care per benefit period and then pay a daily co-pay for days 21 to 100 (up to \$164.50 per day in 2017), after which no Medicare funds are available until the next benefit period.⁷³ Medigap policies, which are private health insurance policies that individuals can purchase to supplement Medicare, cover the co-pay for days 21 to 100 but offer no further long-term care benefits.⁷⁴

The median annual cost of a private room in a nursing home is over \$92,000, and that of a semi-private room is over \$82,000.⁷⁵ Nursing home residents obtain financial support not only from Medicare in limited circumstances, but also from another public program: Medicaid.⁷⁶ Medicaid, however, is available only to impoverished individuals; those with financial resources must “spend down” their assets to qualify for the program.⁷⁷ Detailed guidelines determine Medicaid eligibility, but typically, single people must have no more than \$2,000 in

71. U.S. CTRS FOR MEDICARE & MEDICAID SERVS., YOUR MEDICARE COVERAGE: SKILLED NURSING FACILITY (SNF) CARE, MEDICARE.GOV, <https://www.medicare.gov/coverage/skilled-nursing-facility-care.html> (last visited Nov. 27, 2017) [hereinafter YOUR MEDICARE COVERAGE: SKILLED NURSING FACILITY].

72. *Id.*

73. *See id.* Medicare explains the term “benefit period” as follows:

A benefit period begins the day you're admitted as an inpatient in a hospital or [a skilled nursing facility (SNF)]. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. ...There's no limit to the number of benefit periods.

See also U.S. CTRS. FOR MEDICARE & MEDICAID SERVS. GLOSSARY-B, <http://www.medicare.gov/glossary/b.html> MEDICARE.GOV, (last visited Nov. 27, 2017).

74. U.S. DEP'T OF HEALTH AND HUMAN SERVS., *What is Covered by Health & Disability Insurance?*, LONGTERMCARE.GOV, <http://longtermcare.gov/costs-how-to-pay/what-is-covered-by-health-disability-insurance/> (last visited Sept. 25, 2017).

75. *Compare Long Term Care Costs Across The United States*, GENWORTH FINANCIAL (June 22, 2016), <https://www.genworth.com/about-us/industry-expertise/cost-of-care.html>.

76. U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *Long-Term Services and Support*, Medicaid.gov, <https://www.medicare.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/long-term-services-and-supports.html> (last visited Sept. 25, 2017).

77. U.S. DEP'T OF HEALTH AND HUMAN SERVS., FINANCIAL REQUIREMENTS, LONGTERMCARE.GOV, <https://www.medicare.gov/medicaid/iHS/index.html> (last visited Sept. 25, 2017).

“countable resources” (cash, financial accounts, stocks, bonds, and available assets in trust).⁷⁸

Nevertheless, the majority of people residing in nursing homes are supported by Medicaid.⁷⁹ This may be because those with financial means often prefer other alternatives, such as home care.⁸⁰ According to the Kaiser Family Foundation, in 2014, 62.5% of nursing home residents were covered by Medicaid, 14.2% were covered by Medicare, and 23.3% paid from private sources.⁸¹ Sadly, one study concluded that the median household wealth of individuals who lived in nursing homes for six months or more was only \$5,518.⁸² Arguably, there is no injustice in requiring individuals to exhaust their savings in order to pay for their long-term care, and society should not bear the cost until patients are impoverished. But many people who have worked very hard throughout their lives and take comfort and pride in having money to leave as an inheritance for their loved ones are devastated when they instead must hand over their life savings to nursing homes.⁸³ Others forgo needed care and often suffer catastrophic consequences such as falling and breaking a hip when they are alone in a house that is no longer safe for them.

b. Assisted Living

The median cost of care in an assisted living facility is \$3,628 per month or \$43,536 per year.⁸⁴ These facilities allow residents to have their own apartments or rooms along with assistance in the form of meals in a dining room, cleaning services, personal care, activities,

78. *Id.*; U.S. DEP'T OF HEALTH AND HUMAN SERVS., FINANCIAL REQUIREMENTS-ASSETS, <http://longtermcare.gov/medicare-medicaid-more/medicaid/medicaid-eligibility/financial-requirements-assets/> (last visited Sept 25, 2017).

79. Erica L. Reaves, *Medicaid and Long Term Services and Supports: A Primer*, THE HENRY J. KAISER FOUND. (Dec. 15, 2015), [https://longtermcare.gov/medicare-medicaid-more\(medicaid-eligibility/financial-requirements-assets.html](https://longtermcare.gov/medicare-medicaid-more(medicaid-eligibility/financial-requirements-assets.html).

80. Span, *supra* note 67, at 149.

81. Charlene Harrington et al., *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 through 2015*, THE HENRY J. KAISER FAMILY FOUND. (July 11, 2017), <http://kff.org/report-section/nursing-facilities-staffing-residents-and-facility-deficiencies-facility-characteristics/>.

82. Sudipto Banerjee, *Effects of Nursing Home Stays on Household Portfolios*, EMPLOYEE BENEFITS RES. INST. ISSUE BRIEF, NO. 372, 15 (2012), http://www.ebri.org/pdf/briefspdf/EBRI_IB_06-2012_No372_NrsHmStys.pdf.

83. Geoff Williams, *Some Do's and Don'ts of a Medicaid Spend Down*, U.S. NEWS & WORLD REP. (Apr. 14, 2015), <https://money.usnews.com/money/personal-finance/articles/2015/04/14/some-dos-and-donts-of-a-medicaid-spend-down>.

84. *Id.*

transportation, and more.⁸⁵ While they do not provide skilled nursing services, they can be a good option for frail seniors who can no longer live independently.⁸⁶

Medicare does not offer reimbursement for care in assisted-living facilities.⁸⁷ Most states offer partial Medicaid coverage for eligible low-income enrollees in assisted-living residences.⁸⁸ However, not all assisted-living communities accept Medicaid patients.⁸⁹

c. In-Home Care

Many older adults prefer to remain at home rather than move to an institutional setting such as an assisted living facility or a nursing home.⁹⁰ The national median hourly rate for an aide provided by an in-home care agency is twenty dollars.⁹¹ Thus, an individual seeking round-the-clock care from aides would pay over \$175,000 per year. In 2012, Americans spent an estimated \$77.8 billion on supportive care provided at home.⁹²

The terminology for home care varies and may include two different types of services. “Home health care” generally includes visits by licensed medical personnel providing skilled nursing or rehabilitation services, while “in-home care” includes only non-medical services such as companionship, assistance with activities of daily living (e.g. cooking, dressing, and bathing), driving, and medication reminders.⁹³

85. Span, *supra* note 67, at 113–17.

86. S. HOFFMAN, *supra* note 6, at 88; Lawrence A. Frolik, *Private Long-Term Care Insurance: Not the Solution to the High Cost of Long-Term Care for the Elderly*, 23 ELDER L. J. 371, 388–90 (2016) [hereinafter Frolik].

87. *What Are My Other Long-Term Care Choices?*, U.S. CTRS FOR MEDICARE & MEDICAID SERVS., <https://www.medicare.gov/what-medicare-covers/part-a/other-long-term-care-choices.html#collapse-4917> (last visited Sept. 25, 2017).

88. PAYING FOR SENIOR CARE, *Medicaid's Assisted Living Benefits: Availability and Eligibility*, <https://www.payingforseniorcare.com/medicaid-waivers/assisted-living.html> (last visited Sept. 25, 2017) [hereinafter PAYING FOR SENIOR CARE]; OHIO DEPARTMENT OF AGING, *About Assisted Living*, <https://aging.ohio.gov/services/assistedliving/> (last visited Sept. 25, 2017).

89. PAYING FOR SENIOR CARE, *supra* note 88.

90. Span, *supra* note 67, at 38.

91. *Summary of 2016 Survey Findings*, GENWORTH (May 5, 2016), https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/131168_050516.pdf.

92. *National Health Expenditures 2012 Highlights*, CTRS. FOR MEDICARE & MEDICAID SERV., <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf> (last visited Sept. 25, 2017).

93. *Id.*; GRISWOLD HOME CARE, *Defining Non-Medical Home Care Services: Understanding Your Options*, <http://www.griswoldhomecare.com/services/defining->

Medicare pays for limited home care for homebound elderly people whose doctors approve care plans and who receive services from a Medicare-certified home health agency.⁹⁴ Services may include intermittent skilled nursing, physical therapy, speech therapy, and occupational therapy.⁹⁵ Medicare does not pay for twenty-four-hour-a-day care at home, meal delivery, homemaker services (e.g. cleaning and cooking), or personal care (e.g. dressing and bathing) for those who do not need skilled nursing.⁹⁶ In many states, Medicaid provides low-income individuals with some degree of home care coverage.⁹⁷ Support may also be available through local programs, charities, or, the Veterans Administration.⁹⁸

d. Adult Day Care and Hospice Care

Adult day care provides individuals with activities, meals, recreation, and, in some cases, health care and social services at an adult day care center.⁹⁹ Its average cost in the United States is sixty dollars per

home-care/#ixzz4CPmNheCY (last visited Sept. 25, 2017); *What's Home Health Care & What Should I Expect?*, MEDICARE.GOV (2016), <https://www.medicare.gov/what-medicare-covers/home-health-care/home-health-care-what-is-it-what-to-expect.html>.

94. *Home Health Services*, MEDICARE.GOV, <https://www.medicare.gov/coverage/home-health-services.html> (last visited Sept. 25, 2017) [hereinafter *Home Health Services*].

95. *Id.*

96. *Id.*

97. Tara Bahrapour, *D.C. Program Reflects National Trend Toward Moving Older Americans Out of Nursing Homes*, WASH. POST (Jan. 2, 2014), http://www.washingtonpost.com/local/dc-program-reflects-national-trend-toward-moving-older-americans-out-of-nursing-homes/2014/01/02/8ac1a624-69c7-11e3-ae56-22de072140a2_story.html; *Medicaid Benefits: Personal Care Services: 2012*, KAISER FAMILY FOUND., <http://kff.org/medicaid/state-indicator/personal-care-services/> (last visited Sept. 25, 2017); U.S. DEP'T OF HEALTH AND HUMAN SERVS., STATE MEDICAID PROGRAMS, <http://longtermcare.gov/medicare-medicaid-more/medicaid/> (last visited Sept. 25, 2017).

98. *Paying for Long-Term Care*, NAT'L INST. ON HEALTH, <http://nihseniorhealth.gov/longtermcare/payingforlongtermcare/01.html> (last visited Sept. 25, 2017); U.S. DEP'T OF VETERANS AFFAIRS, GERIATRICS AND EXTENDED CARE: HOMEMAKER AND HOME AIDE CARE, http://www.va.gov/geriatrics/guide/longtermcare/homemaker_and_home_health_aide_care.asp (last visited Sept. 25, 2017).

99. *Adult Day Care*, DEP'T OF HEALTH AND HUMAN SERVS., http://www.eldercare.gov/Eldercare.NET/Public/Resources/Factsheets/Adult_Day_Care.aspx (last visited Sept. 25, 2017) ("The goals of the programs are to delay or prevent institutionalization by providing alternative care, to enhance self-esteem, and to encourage socialization. There are two types of adult day care: adult social day care and adult day health care. Adult social day care provides social activities, meals, recreation, and some health-related services. Adult day health care offers intensive

day.¹⁰⁰ Medicare typically does not pay for this service, though Medicaid does provide payment for eligible low-income enrollees.¹⁰¹

Hospices provide comfort care for terminally ill individuals in the last six months of life.¹⁰² Patients typically receive care at home, but some are admitted to inpatient facilities, especially in their last weeks or days.¹⁰³ Medicare pays for hospice care, but it does not cover room and board for those in inpatient hospice units.¹⁰⁴

e. The Bottom Line

Long-term care costs in the United States reached \$219.9 billion in 2012 and are projected to skyrocket to \$346 billion by 2040.¹⁰⁵ They represent 9.3% of all health care expenditures.¹⁰⁶ Medicaid paid for 61% of long-term care costs because so many individuals were impoverished by the time they needed care or spent down their assets and ultimately qualified for Medicaid coverage.¹⁰⁷ Long-term care costs put a significant strain on Medicaid's budget, almost a third of which is dedicated to these expenditures.¹⁰⁸

health, therapeutic, and social services for individuals with serious medical conditions and those at risk of requiring nursing home care.”).

100. *All About Adult Day Services*, AM. ASS'N RETIRED PERSONS, http://www.aarp.org/relationships/caregiving-resource-center/info-10-2010/pc_all_about_adult_day_services.html (last visited Sept. 25, 2017) [hereinafter *All About Adult Day Services*].

101. *Adult Day Services: The Most Cost-Effective Option in Long-Term Care Today*, NAT'L ADULT DAY SERVICES ASS'N (Apr. 2015), <http://www.nadsa.org/wp-content/uploads/2015/04/Adult-Day-Services-Most-Cost-Effective-Option-in-LTC-2015.pdf>; *Paying for Adult Day Care and Adult Day Health Care*, PAYING FOR SENIOR CARE, https://www.payingforseniorcare.com/longtermcare/find_adult_day_care.html (last visited Sept. 25, 2017).

102. *How Hospice Works*, MEDICARE.GOV, <https://www.medicare.gov/what-medicare-covers/part-a/how-hospice-works.html> (last visited Sept. 25, 2017); DEP'T OF HEALTH AND HUMAN SERVS., MEDICARE HOSPICE BENEFITS 4 (2016), <https://www.medicare.gov/pubs/pdf/02154.pdf> [hereinafter *How Hospice Works*].

103. *Home Health Services*, *supra* note 94.

104. *How Hospice Works*, *supra* note 102, at 7-9.

105. FAMILY CAREGIVER ALL., *supra* note 60; NAT'L HEALTH POL'Y F., *Nat'l Spending for Long-Term Services and Supports (LTSS)*, at 3 (Mar. 3, 2014), https://www.nhpf.org/library/the-basics/Basics_LTSS_03-27-14.pdf [hereinafter NAT'L HEALTH POL'Y F.].

106. NAT'L HEALTH POL'Y F., *supra* note 105, at 1.

107. *Id.* at 3. *But see* Erica L. Reaves & Mary Beth Musumeci, *Medicaid and Long-Term Services and Supports: A Primer*, KAISER FAMILY FOUND. (Dec. 15, 2015), <http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/> (finding that long-term care expenditures in the U.S. totaled \$310 billion, and that Medicaid covered 51% of those costs) [hereinafter Reaves & Musumeci].

108. NAT'L HEALTH POL'Y F. *supra* note 105, at 4; Reaves & Musumeci, *supra* note 107 (placing the figure at 28%); *The Critical Need for Long-Term Services and Supports*

Most of the costs not covered by Medicaid are paid by individuals out of private sources.¹⁰⁹ Thus, individuals who are not Medicaid-eligible frequently forgo needed care or rapidly exhaust their life savings because of extremely high out-of-pocket costs. In fact, almost one-fifth of seniors spend over \$25,000 of their own money for long-term care before they die.¹¹⁰ Recall that the median retirement savings for people nearing retirement is \$14,500.¹¹¹ Consequently, individuals with high long-term care costs often find themselves impoverished and supported by Medicaid in nursing homes that are a choice of last resort.¹¹²

Many Americans are lucky enough to receive unpaid care from family and friends.¹¹³ But such care also has significant costs,¹¹⁴ though these are absorbed by the caregivers. The costs can include physical and emotional strain, out of pocket costs, lost income because of time away from work, or stalled careers.¹¹⁵

2. LONG-TERM CARE INSURANCE

Individuals who are concerned about potentially paying hundreds of thousands of dollars out of pocket for long-term care can attempt to insure themselves against this risk by purchasing long-term care insurance. Unfortunately, this option is unavailable or unaffordable for many and is often a bad choice even for those who are able to obtain it.¹¹⁶

Only about 3% of Americans have long-term care insurance policies.¹¹⁷ Some who would be interested in purchasing policies are barred

Financing Reform, NAT'L COUNCIL ON AGING (Mar. 2016), <https://www.ncoa.org/wp-content/uploads/IB16-LTSS-Financing-Need-March.pdf> (stating that "[t]here is a great risk that spending on LTSS will squeeze out other state spending priorities, such as education and basic health coverage for low-income individuals") [hereinafter NAT'L COUNCIL ON AGING].

109. NAT'L HEALTH POL'Y F., *supra* note 105, at 3.

110. FAMILY CAREGIVER ALL., *supra* note 60.

111. See Rhee & Boivie, *supra* note 47 and accompanying text.

112. Span, *supra* note 67, at 113 (noting that "[n]obody wants to go to a nursing home, indispensable as they sometimes are; seniors and their families tend to shudder at the very phrase").

113. See ALZHEIMER'S ASS'N, *supra* notes 31 and accompanying text of notes 36-37.

114. See A. Hoffman, *supra* note 38, at 246.

115. *Id.* at 272.

116. See Frolik, *supra* note 86, at 372.

117. Iglehart, *supra* note 22, at 182.

by strict eligibility criteria.¹¹⁸ For example, those with memory loss, mobility limitations, stroke histories, or even mild osteoporosis may be deemed ineligible for coverage.¹¹⁹

For many others, long term care insurance is unappealing because of the policies' high cost compared to their benefits. Long-term care insurance policies cover nursing home stays, assisted living, adult day care, and home care, but different contract terms specify the conditions under which coverage is triggered.¹²⁰ Typically, coverage becomes available when the policy holder needs significant assistance with a minimum of two activities of daily living (e.g. bathing and dressing) because of physical limitations that are expected to last at least ninety days or because of severe cognitive impairment.¹²¹ Before this point of advanced disability, the insurer will not reimburse policy-holders for their expenses even if they need significant help and hire professional caregivers.¹²²

Policies generally have a variety of limitations. Most exclude coverage for an initial period of time, ranging from thirty to ninety days.¹²³ They also often restrict benefits to no more than three to five years, and only about one-quarter allow for benefits of unlimited duration.¹²⁴ In addition, most policies limit benefits to a maximum dollar amount per day, which will likely be lower than the daily cost of care.¹²⁵

Of even greater concern is the extremely high cost of insurance premiums, which generally reach several thousand dollars per year.¹²⁶ For example, the American Association of Long-Term Care Insurance states that a fifty-five-year-old individual may pay as much as \$3,150

118. See, e.g., YOUR MEDICARE COVERAGE: SKILLED NURSING FACILITY, *supra* note 71.

119. Kelly Greene, *Long-Term Care: What Now?*, WALL ST. J. (Mar. 9, 2012), <http://online.wsj.com/articles/SB10001424052970203961204577269842991276650>.

120. Jeffrey R. Brown & Amy Finkelstein, *Insuring Long-Term Care in the United States*, 25 J. ECON. PERSPECTIVES 119, 122 (2011) [hereinafter Brown & Finkelstein]; Richard W. Johnson & Janice S. Park, *Who Purchases Long-Term Care Insurance?*, URBAN INST. OLDER AMERICANS' ECON. SECURITY (Mar. 2011), <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412324-Who-Purchases-Long-Term-Care-Insurance-.PDF> [hereinafter Johnson & Park].

121. See generally Johnson & Park, *supra* note 120.

122. *Id.*

123. Frolik, *supra* note 86, at 393.

124. *Id.* at 381; Brown & Finkelstein, *supra* note 120, at 125.

125. Brown & Finkelstein, *supra* note 120, at 125.

126. *How Much Does Long Term Care Insurance Cost? Here Are Costs for 2015 for Leading Long-Term Care Insurers*, AM. ASS'N OF LONG-TERM CARE INS., <http://www.aaltci.org/long-term-care-insurance/learning-center/long-term-care-insurance-costs-2015.php> (last visited Sept. 25, 2017).

per year for a policy that will pay up to \$365,000 if the person does not utilize benefits until the age of eighty-five.¹²⁷ By age eighty-five, however, the person will have paid \$94,500 in premiums over thirty years, and that money may have grown substantially had it been invested wisely elsewhere.¹²⁸ Moreover, the insured may die without ever qualifying for insurance coverage, and thus, the tens of thousands of dollars of premium payments will yield no financial benefit to them or their heirs.

It is also noteworthy that buyers have little choice in the long-term care insurance market. Today, as few as eighteen insurers nationwide offer this financial product.¹²⁹ Those that have stayed in the market often raise premium rates in order to remain profitable.¹³⁰

A growing number of commentators argue that contemporary long-term care policies are not a prudent investment for many or even most consumers.¹³¹ According to one source, in light of the policies' high premiums and benefit restrictions, the typical policyholder can expect to receive only sixty-eight cents in benefits for every dollar paid in premiums.¹³² A law review article entitled *Private Long-Term Care Insurance: Not the Solution to the High Cost of Long-Term Care for the Elderly* provides a detailed critique of the limitations of these insurance policies.¹³³ Articles with titles such as *Long-Term Care Insurance: Less Bang,*

127. *Id.*

128. *Id.*

129. Iglehart, *supra* note 22, at 184; Frolik, *supra* note 86, at 410–13 (stating that some insurers are now offering hybrid long-term care policies in which either life insurance or an annuity is bundled with long term care coverage. Thus, the insurance product includes an investment component in the form of either an annuity or a death benefit. One challenge posed by these hybrid products is that they generally require very large initial premium payments, such as \$50,000.); Enrique Zamora et al., *Long-Term Care Insurance: A Life Raft for Baby Boomers*, 26 ST. THOMAS L. REV. 79, 96 (2013); Howard Gleckman, *The Traditional Long-Term Care Insurance Market Crumbles*, FORBES, Sept. 8, 2017, <https://www.forbes.com/sites/howardgleckman/2017/09/08/the-traditional-long-term-care-insurance-market-crumbs/#45d569b3ec33> (asserting that only “17 carriers sold traditional long-term care policies in 2016”).

130. Kelly Greene, *Long-Term Care: What Now?*, WALL ST. J. (Mar. 9, 2012), <http://online.wsj.com/articles/SB10001424052970203961204577269842991276650>.

131. See S. HOFFMAN, *supra* note 6, at 7–11.

132. *Id.* at 126–27. For an accurate estimate, the calculation must take into account the present discounted values of premiums and benefits. The idea is that money that one has at present is worth more than money one will obtain in the future because it can earn interest or be invested in the interim.

133. Frolik, *supra* note 86, at 390–410.

*More Buck*¹³⁴ and *Why No One Can Afford Long-Term Care Insurance (and What to Use Instead)*¹³⁵ are reaching the popular press as well.

Congress attempted to remedy the long-term care insurance cost problem with the Community Living Assistance Services and Supports (CLASS) Act, which was part of President Obama's Patient Protection and Affordable Care Act of 2010 (ACA or Obamacare).¹³⁶ The law would have enabled the federal government to sell private long-term care insurance policies directly to the public.¹³⁷ This program, however, was abandoned in 2011 because it was deemed not to be financially viable.¹³⁸ In 2013, Congress created a bipartisan Commission on Long-Term Care that issued a report with twenty-eight recommendations for the improvement of long-term care in the United States.¹³⁹ The commission, however, failed to formulate recommendations regarding the critical issue of financing because it could not reach consensus on this matter.¹⁴⁰

While the ACA took important (though perhaps temporary) steps to improve Americans' access to health insurance and health care, it did not ultimately address the problem of long-term care. Much work remains for federal and state legislatures to resolve the question of how Americans will meet their long-term care needs.

3. CAREGIVERS' JOB SATISFACTION

Cost is not the sole barrier to receiving adequate long-term care. The poor working conditions that many caregivers face is another.

134. Barbara Feder Ostrov, *Long-Term Care Insurance: Less Bang, More Buck*, KAISER HEALTH NEWS (Mar. 17, 2016), <http://khn.org/news/long-term-care-insurance-less-bang-more-buck/>.

135. Maryalene LaPonsie, *Why No One Can Afford Long-Term Care Insurance (and What to Use Instead)*, U.S. NEWS & WORLD REP. (Mar. 10, 2016, 10:47 AM), <http://money.usnews.com/money/personal-finance/articles/2016-03-10/why-no-one-can-afford-long-term-care-insurance-and-what-to-use-instead>.

136. Community Living Assistance Services and Supports ("CLASS Act") Act Pub. L. No. 111-148, 124 Stat. 148 (2010) [hereinafter CLASS].

137. Peter Kyle, *Confronting the Elder Care Crisis: The Private Long-Term Care Insurance Market and the Utility of Hybrid Products*, 15 MARQ. ELDER'S ADVISOR 101, 121-24 (2013) [hereinafter Kyle].

138. Letter from Secretary Sebelius to Congress about CLASS (Oct. 14, 2011), <http://www.ltccconsultants.com/articles/2011/class-dismissed/Sebelius-CLASS-Letter.pdf> [hereinafter Letter from Secretary].

139. U.S. COMM'N ON LONG TERM CARE: REP. TO THE CONG. 35-77 (Sept. 18, 2013), <http://ltcccommission.org/ltcccommission/wp-content/uploads/2013/12/Commission-on-Long-Term-Care-Final-Report-9-26-13.pdf>.

140. *Id.* at 60-62; Iglehart, *supra* note 22, at 185-86.

Home care aides are typically female and have no more than a high school education, and they are often underpaid and overworked.¹⁴¹ Aides' average hourly wage in 2015 was \$11.00, and their average annual salary was \$22,740.¹⁴² Their annual turnover rate is considerable, perhaps as high as 65%, and it is attributable to low pay, few benefits, stress, and injuries suffered while lifting and moving clients.¹⁴³ Caregiver unhappiness and recurrent staffing changes can be very distressing for the elderly, especially for people with dementia.¹⁴⁴ Workers who do not perceive caregiving as a promising long-term career may also be less devoted to their jobs and their clients.¹⁴⁵ Consequently, a comprehensive solution to the long-term care problem in the United States must include consideration of the needs of the caregiver workforce.¹⁴⁶

C. Driving

Long-term care is not the only area in which legislatures and regulators have been inattentive to the needs of the elderly. Driving is another neglected area, and in many cases it causes significant angst.¹⁴⁷

141. *Shortage of Nurse Aides, Home Health Aides, and Personal-and-Home-Care Aides Projected*, HEALTHCARE ADMIN., <http://www.healthcareadministration.com/shortage-of-nurse-aides-home-health-aides-and-personal-and-home-care-aides-projected/> (last visited Sept. 25, 2017) [hereinafter *Shortage of Nurse Aides*].

142. *Occupational Employment and Wages, May 2015, Home Health Aides*, U.S. DEP'T OF LAB. BUREAU OF LABOR STAT., <http://www.bls.gov/oes/current/oes311011.htm> (last visited Sept. 25, 2017).

143. Sarah Protlock, *Help Wanted (a Lot): Home-Health Aides*, WALL ST. J. (Aug. 22, 2014, 11:30 AM), <http://www.wsj.com/articles/help-wanted-a-lot-home-health-aides-1408721457>; *Shortage of Nurse Aides*, *supra* note 141; see also Ayesha Hardaway, *The Paradox of the Right to Contract: Noncompete Agreements as Thirteenth Amendment Violations*, 39 SEATTLE UNIV. L. REV. 957, 963-65 (2016). In some cases aides are required to sign non-compete agreements that restrict their ability to work for other home health agencies. Therefore, if they are dissatisfied with their particular jobs, they must either remain with the same employer despite their unhappiness or leave the industry altogether.

144. S. HOFFMAN, *supra* note 6, at 90; Ashley Huntsberry-Lett, *How to Select a Home Care Company*, AGINGCARE.COM, <https://www.agingcare.com/articles/dont-make-these-mistakes-when-hiring-home-health-care-135896.htm>, (last visited Sept. 25, 2017).

145. See generally *Shortage of Nurse Aides*, *supra* note 141.

146. See Joseph White, *(How) Is Aging a Health Policy Problem?*, 4 YALE J. HEALTH POL'Y L. & ETHICS 47, 63 (2004) (stating that "[h]elping people to dress, eat, urinate, and defecate simply is not an attractive career. Dealing with individuals in various stages of dementia is trying"); A. Hoffman, *supra* note 38, at 198, 228 (explaining that higher wages would be very helpful, but on their own they are insufficient because of other sources of job dissatisfaction).

147. Elena Kulikov, *The Social and Policy Predictors of Driving Mobility Among Older Adults*, 23 J. AGING & SOC. POL'Y 2 (2011).

States generally fail to screen elderly drivers adequately, fail to provide them with guidance as to the conditions under which it is safe for them to drive, and neglect to ensure that those who may pose a risk to themselves and others relinquish their licenses.¹⁴⁸

In 2014, there were 24.4 million licensed drivers in the United States who were seventy and older.¹⁴⁹ In fact, some people continue to drive even after they reach the age of 100; in 2013, Florida reported 455 licensed drivers who were 100 or older.¹⁵⁰

As individuals age, a number of problems, such as cognitive decline, physical ailments, poor vision, and side effects from medications, can compromise their driving ability.¹⁵¹ In 2014, over 5,700 older adults were killed and more than 236,000 were injured in car accidents.¹⁵² By comparison, that same year 2,623 teenagers (ages 13–19) died in motor vehicle crashes, and the death rate for all age groups was 21,102.¹⁵³ Overall, approximately 2.35 millions people are injured in car crashes every day.¹⁵⁴

Happily, older drivers frequently engage in some degree of self-regulation. They are likely to wear seatbelts, to limit driving in bad weather and at night, to avoid driving long distances, and to drive sober.¹⁵⁵ Nevertheless, according to the Centers for Disease Control and Prevention (CDC), “[p]er mile traveled, fatal crash rates increase noticeably starting at ages 70–74 and are highest among drivers age 85 and older.”¹⁵⁶ The American Medical Association and National Highway

148. *Id.*

149. *Older Drivers*, INS. INST. FOR HIGHWAY SAFETY & HIGHWAY LOSS DATA INST., <http://www.iihs.org/iihs/topics/t/older-drivers/qanda> (last visited Sept. 25, 2017).

150. Shelley Emling, *Study Shows Surprising Number of Drivers Over 100*, HUFFINGTON POST (Sept. 23, 2013), http://www.huffingtonpost.com/2013/09/23/older-drivers_n_3975579.html.

151. *Older Adult Drivers*, CTRS. FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/motorvehiclesafety/older_adult_drivers/ (last visited Sept. 25, 2017) [hereinafter *Older Adult Drivers*].

152. *Id.*

153. *Teenagers*, INS. INST. FOR HIGHWAY SAFETY & HIGHWAY LOSS DATA INST., <http://www.iihs.org/iihs/topics/t/teenagers/fatalityfacts/teenagers/2014> (last visited Nov. 27, 2017).

154. *Annual United States Road Crash Statistics*, Ass’n for Safe Int’l Road Travel, <http://asirt.org/initiatives/informing-road-users/road-safety-facts/road-crash-statistics> (last visited Sept. 25, 2017).

155. *Older Adult Drivers*, *supra* note 151.

156. *Compare with Teen Drivers: Get the Facts*, CTRS. FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/motorvehiclesafety/teen_drivers/teendrivers_factsheet.html (last updated October 14, 2015) (“The risk of motor vehicle crashes is higher among 16-19-year-olds than among any other age group.”).

Traffic Safety Association add that “[o]n the basis of estimated annual travel, the fatality rate for drivers 85 and older is 9 times higher than the rate for drivers 25 to 69.”¹⁵⁷ The CDC notes, however, that the high fatality rate is largely attributable to older people’s frailty and inability to recover from serious injuries.¹⁵⁸

In light of the high number of injuries and fatalities, it is surprising that states make only feeble efforts to scrutinize driver license renewal applications by elderly drivers. In 2017, eighteen states had shorter renewal periods for drivers older than a specific age, and eighteen states mandated that older drivers undergo vision testing more often.¹⁵⁹ Sixteen states and the District of Columbia required older drivers to renew their licenses in person, whereas younger drivers could do so by mail or online.¹⁶⁰ Only the District of Columbia required that physicians approve license renewals for older individuals (starting at age seventy), and only Illinois required a road test for seniors (those older than seventy-five at the time of renewal).¹⁶¹

Perhaps more troubling is the lack of structured mechanisms, beyond license renewals, by which states can identify individuals who are unsafe drivers. Only six states mandate that physicians report at-risk drivers to state authorities, though all states permit doctors to do so.¹⁶² States vary as to whether they accept reports from family members, friends, or anonymous sources.¹⁶³ In addition, only about half the states are known to train law enforcement officers to recognize and report medically at-risk drivers.¹⁶⁴ Thus, many police officers who are called to the scenes of accidents involving elderly drivers simply ticket them

157. A.M.A. & NAT’L HIGHWAY TRAFFIC SAFETY ADMIN., PHYSICIAN’S GUIDE TO ASSESSING AND COUNSELING OLDER DRIVERS 5 (2nd ed. 2010) <http://www.aarp.org/content/dam/aarp/livable-communities/plan/transportation/older-drivers-guide.pdf> [hereinafter PHYSICIAN’S GUIDE].

158. *Older Adult Drivers*, *supra* note 151.

159. *Older Drivers: License Renewal Procedures*, INS. INST. FOR HIGHWAY SAFETY, <http://www.iihs.org/iihs/topics/laws/olderdrivers> (last visited Sept. 25, 2017).

160. *Id.*

161. *Id.*

162. *Driver Licensing and Policies: Physician Reporting of At-Risk Drivers*, AAA FOUND. FOR TRAFFIC SAFETY, <http://lpp.seniordrivers.org/lpp/index.cfm?selection=reportingdrs1&orderby=abbv&sortorder=asc&country=USA> (last updated June 6, 2016) (noting the states of California, Delaware, New Jersey, Nevada, Oregon, and Pennsylvania).

163. *Driver Licensing as Policies: Family & Friend Reporting of At-Risk Drivers*, AAA FOUND. FOR TRAFFIC SAFETY, <http://lpp.seniordrivers.org/lpp/index.cfm?selection=reportingfamilyfriends1> (last visited Sept. 25, 2017).

164. *Driver Licensing And Policies: Law Enforcement Reporting of At-Risk Drivers*, AAA FOUND. FOR TRAFFIC SAFETY, <http://lpp.seniordrivers.org/lpp/index.cfm?selection=lawenforcement> (last visited Sept. 25, 2017).

and require no follow-up even if the drivers seem confused or have histories of multiple recent collisions.¹⁶⁵

Intervention, therefore, is left largely to families who often find themselves having to confront loved ones about driving with little support or guidance from government sources.¹⁶⁶ Such confrontations can be traumatic and cause lasting conflict and emotional distress.¹⁶⁷ Unfortunately, in many locations, public transportation, which could help those who are robust enough to use it, is sorely inadequate or nonexistent.¹⁶⁸ A report written in 2011 estimated that by 2015, more than 15.5 million older Americans would face poor transit access.¹⁶⁹ Thus, the cessation of driving can dramatically impact seniors' quality of life, including their ability to reach stores, pharmacies, or medical facilities, and their opportunities for social and intellectual interaction.¹⁷⁰

Admittedly, there is uncertainty as to which regulations will make the roads safest. California pilot-tested a three-tier evaluation for anyone wishing to renew a driver's license.¹⁷¹ The first tier (Tier 1) screening consisted of a brief memory recall test, two vision tests, and the tester's observation of any visible physical limitations.¹⁷² The second tier (Tier 2) consisted of a written test of driving knowledge.¹⁷³ It also featured a Perceptual Response Test, designed to identify limitations in perception and cognition that are relevant to driving, which California

165. *Id.*; *Driver Licensing And Policies: Driver Medical Review Process / States WITH Medical Advisory Board (MAB)*, AAA FOUND. FOR TRAFFIC SAFETY, <http://lpp.seniordrivers.org/lpp/index.cfm?selection=statesMAB> (last updated Sept. 12, 2016). If a state is notified of an at-risk driver, it may intervene in a number of ways. State authorities will likely first consult the state's medical advisory board if one exists, the driver's physician, or another health care provider. Short of revoking the elderly person's license, the state may impose driving restrictions, such as prohibiting driving on high-speed roads, at night, or further than a certain distance from home. *Driver Medical Review Process / States WITHOUT Medical Advisory Board (MAB)*, AAA FOUND. FOR TRAFFIC SAFETY, <http://lpp.seniordrivers.org/lpp/index.cfm?selection=statesnoMAB> (last visited Sept. 25, 2017); *Driver Licensing as Policies: Types of Conditions or Restrictions on Licenses, Page 1*, AAA FOUND. FOR TRAFFIC SAFETY, <http://lpp.seniordrivers.org/lpp/index.cfm?selection=restrictedlicensetypes1> (last updated Sept. 12, 2016).

166. S. HOFFMAN, *supra* note 6, at 63.

167. *Id.* at 65.

168. Kevin DeGood et al., *AGING IN PLACE, STUCK WITHOUT OPTIONS: FIXING THE MOBILITY CRISIS THREATENING THE BABY BOOM GENERATION 18* (David Goldberg et al. eds., 2011), <http://t4america.org/docs/SeniorsMobilityCrisis.pdf>.

169. *Id.* at 15.

170. *PHYSICIAN'S GUIDE*, *supra* note 157, at 2.

171. CALIFORNIA DEPARTMENT OF MOTOR VEHICLES, *CALIFORNIA'S THREE-TIER DRIVING-CENTERED ASSESSMENT SYSTEM: OUTCOME ANALYSIS vi-vii* (2011).

172. *Id.* at vi.

173. *Id.*

administered to those who failed Tier 1 testing or the Tier 2 written examination.¹⁷⁴ Individuals identified as at-risk drivers in the first two tiers were required to take a road test and undergo an educational intervention in Tier 3.¹⁷⁵ The state found no evidence that the program reduced crash risks among participants in general and older drivers in particular.¹⁷⁶ A study in Maryland, however, indicated that individuals who were seventy-eight and older and performed poorly on certain cognitive tests were twice as likely as other drivers to cause collisions.¹⁷⁷

Researchers have also determined that the visual acuity tests that are currently performed are not effective in identifying drivers at risk for collision.¹⁷⁸ They speculate that “contrast sensitivity, visual field, processing speed, and divided attention tests” would be better screening tools.¹⁷⁹

Regulators might hesitate to regulate elderly drivers more rigorously than others because of concerns about age discrimination. Under the Equal Protection clause,¹⁸⁰ however, age discrimination is subject only to rational basis scrutiny.¹⁸¹ Courts would likely find that increased injuries and fatalities among older drivers justify government intervention. In the alternative, states could apply stricter renewal standards and post-accident scrutiny to drivers of all ages in order to avoid potential Equal Protection violations, though this is a more costly option.¹⁸²

D. Geriatric Medical Care

Many older Americans suffer from multiple health problems.¹⁸³ Among them, millions are chronic pain patients.¹⁸⁴

174. *Id.*

175. *Id.* at vi-vii.

176. *Id.* at xix.

177. Karlene K. Ball et al., *Can High-Risk Older Drivers Be Identified Through Performance-Based Measures in a Department of Motor Vehicles Setting?*, 54 J. AM. GERIATRICS SOC. 77, 81 (2006) [hereinafter Ball et al.].

178. Cynthia Owsley & Gerald McGwin Jr., *Vision and Driving*, 50 VISION RES. 2348, 2357 (2010) [hereinafter Owsley & McGwin Jr.].

179. *Id.*

180. U.S. CONST. amend. XIV, § 1 (providing that no state shall “deny to any person within its jurisdiction the equal protection of the laws”).

181. Nina A. Kohn, *Rethinking the Constitutionality of Age Discrimination: A Challenge to a Decades-Old Consensus*, 44 U.C. DAVIS L. REV. 213, 217-19 (2010).

182. Ball et al., *supra* note 177, at 82.

183. *See supra* notes 26-27 and accompanying text.

184. Ivan R. Molton & Alexandra L. Terrill, *Overview of Persistent Pain in Older Adults*, 69 AM. PSYCHOLOGIST 197, 197 (2014); AAPM *Facts and Figures on Pain*,

To treat their maladies, the elderly often visit a number of different specialists, including cardiologists, oncologists, rheumatologists, endocrinologists, psychologists, pain-management experts, and others.¹⁸⁵ Studies have found that elderly patients see specialists more often than general internists, and up to a third see specialists but no primary care physicians at all.¹⁸⁶ According to one study, the elderly see an average of four different specialists a year.¹⁸⁷ Furthermore, according to the CDC, 65% of seniors take three or more prescription medications, and 39% take five or more prescription drugs.¹⁸⁸

Patients can receive expert, life-saving care from specialists. Their care, however, may also become fragmented and uncoordinated, with each specialist focusing only on her area of expertise and providing aggressive treatment for a single problem.¹⁸⁹ This approach, in turn, can lead to harmful interactions among different drugs, overly aggressive treatment that does not benefit the patient's overall health, or interventions that cause cognitive decline and other complications.¹⁹⁰

A prudent approach to avoiding the adverse effects of care fragmentation is to have skilled geriatricians oversee and coordinate care

AM. ACAD. OF PAIN MED., http://www.painmed.org/patientcenter/facts_on_pain.aspx (last visited Sept. 25, 2017).

185. Sandeep Jauhar, *One Patient, Too Many Doctors: The Terrible Expense of Over-specialization*, TIME (Aug. 19, 2014), <http://time.com/3138561/specialist-doctors-high-cost/> [hereinafter Jauhar].

186. Elizabeth J. Bragg et al., *The Development of Academic Geriatric Medicine in the United States 2005 to 2010: An Essential Resource for Improving the Medical Care of Older Adults*, 60 J. AM. GERIATRICS SOC'Y 1540, 1543 (2012) (stating that "56% of all ambulatory visits by patients aged 75 and older in 2008 were to specialty care physicians") [hereinafter Bragg et al.]; Barbara Starfield et al., *Ambulatory Specialist Use by Non-hospitalized Patients in US Health Plans: Correlates and Consequences*, 32 J. AMB. CARE MANAGEMENT 216, 218 (2009) [hereinafter Starfield et al.].

187. Starfield et al., *supra* note 186, at 222; see also Claudia Grossmann et al., *Engineering a Learning Healthcare System: A Look at the Future: Workshop Summary 123* (2011), <http://www.nap.edu/catalog/12213/engineering-a-learning-health-care-system-a-look-at-the-future> (stating that a "Medicare beneficiary sees a median of two primary care providers and five specialists per year") [hereinafter Grossman et al.].

188. U.S. DEP'T OF HEALTH AND HUMAN SERVS. ET AL., HEALTH, UNITED STATES, 2015: *With Special Feature on Racial and Ethnic Health Disparities* 272 (2016), <http://www.cdc.gov/nchs/data/hus/15.pdf#079> (using 2009–2012 data).

189. Jauhar, *supra* note 185.

190. S. HOFFMAN, *supra* note 6, at 68–70; Grossmann et al., *supra* note 187, at 15 (quoting Johns Hopkins' Amy L. Deuschendorf as stating that "[p]atient care is now so fragmented, disorganized, and disconnected that safety and quality depends on the ability of patients and providers to communicate and work together more effectively . . .").

for patients with multiple medical problems.¹⁹¹ Geriatricians are physicians with special training in evaluating and managing the health needs of older adults.¹⁹²

Geriatricians can oversee and coordinate elderly patients' care, and they are attuned to subtle problems that often escape the attention of other specialists. These include deficiencies in "balance, gait, strength, hearing, vision, and memory" that can significantly impact an older adult's quality of life and portend illnesses to come.¹⁹³ Dr. Atul Gawande, a surgeon and journalist, explains the need for geriatric specialists as follows:

Most of us in medicine . . . don't know how to think about decline. We're good at addressing specific, individual problems: colon cancer, high blood pressure, arthritic knees. Give us a disease, and we can do something about it. But give us an elderly woman with colon cancer, high blood pressure, arthritic knees, and various other ailments besides—an elderly woman at risk of losing the life she enjoys—and we are not sure what to do.¹⁹⁴

Unfortunately, the United States faces a grave shortage of geriatricians.¹⁹⁵ Currently, there are approximately 7,500 certified geriatricians nationwide, or one for every 2,526 Americans who are seventy-five or older.¹⁹⁶ Because of the imminent growth of the elderly population and physicians' reluctance to specialize in geriatrics, experts anticipate that by 2030, the ratio will drop to one geriatrician for every 4,484

191. Atul Gawande, *The Way We Age Now*, THE NEW YORKER (Apr. 30, 2007), <http://www.newyorker.com/magazine/2007/04/30/the-way-we-age-now> [hereinafter Gawande].

192. Magaly Olivero, *Doctor Shortage: Who Will Take Care of the Elderly?*, U.S. NEWS & WORLD REP. (Apr. 21, 2015), <http://health.usnews.com/health-news/patient-advice/articles/2015/04/21/doctor-shortage-who-will-take-care-of-the-elderly> [hereinafter Olivero].

193. Jonathan Peterson, *Where Are the Doctors You'll Need?*, AARP BULLETIN 1, 9–10 (Apr. 2016).

194. Gawande, *supra* note 191.

195. Barbara Sadick, *A Remedy for the Looming Geriatrician Shortage*, WALL ST. J. (June 8, 2014), <http://www.wsj.com/articles/a-remedy-for-the-looming-geriatrician-shortage-1402001802> [hereinafter Sadick]; John W. Rowe et al., *Preparing for Better Health and Health Care for an Aging Population*, 316 NAT'L ACAD. MED. 1543, 1643 (2016) (decrying the inadequacy of the elder care workforce).

196. *Frequently Asked Questions about Geriatrics*, AMERICAN GERIATRICS SOC'Y, http://www.americangeriatrics.org/advocacy_public_policy/gwps/gwps_faqs/ (last visited Sept. 25, 2017) [hereinafter FAQ about Geriatrics].

patients in this age group.¹⁹⁷ In 2013, only 319 physicians entered geriatric medicine fellowships, and of those, 203 graduated from medical schools outside the United States.¹⁹⁸

Not surprisingly, a primary reason for the dearth of geriatricians in the United States is financial. Despite their many years of education, geriatricians cannot expect to become wealthy. They are reimbursed largely by Medicare, which often pays physicians less than private insurance policies.¹⁹⁹ In 2010, the median salary of geriatricians in private practice was \$183,523, whereas that of a neurologist was \$249,867.²⁰⁰ The comparatively low earning potential is justifiably a concern for many contemporary medical school graduates whose educational debts averaged \$178,046 in 2014.²⁰¹ In addition, geriatricians face unpredictable work hours, patients with multiple and complex problems, and the prospect of managing chronic diseases rather than successfully curing them, which may be unappealing to many medical students.²⁰²

Dr. Heather Whitson of the Duke University School of Medicine warns that our nation is facing a crisis. She asserts that “[o]ur current health care system is ill equipped to provide the optimal care experience for patients with multiple chronic conditions or with functional limitations and disabilities.”²⁰³ The alarming shortage of geriatricians is another pitfall that cries out for attention.

E. Human Rights Doctrine

It is noteworthy that even in the human rights arena, the elderly have been somewhat neglected compared to other vulnerable populations.²⁰⁴ Three cornerstone documents form the “Bill of Rights” in international human rights doctrine: the Universal Declaration of Human

197. *Id.*

198. *Id.*; see also Jean Y. Campbell et al., *The Unknown Profession: A Geriatrician*, 61 J. AM. GERIATRICS SOC’Y 447, 447 (2013).

199. Olivero, *supra* note 192; *FAQ about Geriatrics*, *supra* note 196.

200. Ball et al., *supra* note 177 (stating that the average general internist’s salary was higher than a geriatrician’s by \$21,856); Bragg et al., *supra* note 186, at 1544.

201. *FAQ about Geriatrics*, *supra* note 196.

202. *Id.*; Liz Seegert, *Aging Boomers Highlight Need for More Geriatric Specialists*, CONN. HEALTH INVESTIGATIVE TEAM (June 6, 2016), <http://c-hit.org/2016/06/06/aging-boomers-highlight-need-for-more-geriatric-specialists/> [hereinafter Seegert].

203. Olivero, *supra* note 192.

204. Marthe Fredvang & Simon Biggs, *The Rights of Older Persons: Protection and Gaps under Human Rights Law* 5, BROTHERHOOD OF ST. LAURENCE AND UNIVERSITY OF MELBOURNE CENTRE FOR PUBLIC POLICY SOCIAL POLICY WORKING PAPER NO. 16

Rights, the International Covenant on Civil and Political Rights, and the International Covenant on Economic, Social and Cultural Rights.²⁰⁵ Beyond the “Bill of Rights” are seven other core conventions: the Convention on the Elimination of All Forms of Racial Discrimination; the Convention on the Elimination of All Forms of Discrimination against Women; the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; the Convention on the Rights of the Child; the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families; the Convention on the Rights of Persons with Disabilities; and the International Convention for the Protection of all Persons from Enforced Disappearance.²⁰⁶

None of these key international treaties focuses on the rights of older adults.²⁰⁷ This is not to say that the elderly have been completely ignored by the United Nations (UN). Several non-binding “soft law” initiatives have been undertaken. In 1982, the World Assembly on Ageing adopted the Vienna International Plan of Action on Ageing.²⁰⁸ Two decades later, the Second World Assembly on Ageing adopted the Madrid International Plan of Action on Ageing.²⁰⁹ In the interim, in 1991,

(August 2012), <http://social.un.org/ageing-working-group/documents/fourth-Rightsfolderpersons.pdf> [hereinafter Fredvang & Biggs].

205. Universal Declaration of Human Rights, July 2003 2220 U.N.T.S. I, 73; International Covenant on Civil and Political Rights, Dec. 16, 1966, S. Treaty Doc. No. 95-20, 6 I.L.M. 368 (1967), 999 U.N.T.S. 171; International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, S. Treaty Doc. No. 95-19, 6 I.L.M. 360 (1967), 993 U.N.T.S. 3.

206. International Convention on the Elimination of All Forms of Racial Discrimination, Mar. 7, 1966, 660 U.N.T.S. 195; Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979, 1249 U.N.T.S. 13; Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Dec. 10, 1984, 1465 U.N.T.S. 85; Convention on the Rights of the Child, Nov. 20, 1989, 1577 U.N.T.S. 3; International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, Dec. 18, 1990, 2220 U.N.T.S. 3; Convention on the Rights of Persons with Disabilities, Dec. 13, 2006, 2515 U.N.T.S.3; International Convention for the Protection of all Persons from Enforced Disappearance, Dec. 20, 2006, 2716 UNTS 3. *See also* Fredvang & Biggs, *supra* note 204, at 9–10.

207. Jaclynn M. Miller, *International Human Rights and the Elderly*, 11 MARQ. ELDER’S ADV. 343, 363 (2010) [hereinafter Miller].

208. U.N., *Vienna International Plan of Action on Aging* (1983), http://www.monitoringris.org/documents/norm_glob/vipaa.pdf.

209. U.N., *Madrid International Plan of Action on Ageing* (2002), http://www.un.org/en/events/pastevents/pdfs/Madrid_plan.pdf.

the UN General Assembly adopted resolution 46/91, the United Nations Principles for Older Persons.²¹⁰ Nevertheless, human rights advocates have noted the inequity among vulnerable populations and argued that the elderly merit a formal international treaty that focuses on protection of their rights.²¹¹

III. Why Elder Matters Are Not a Political Priority

Based on their numbers and voting rates, seniors should be a population about whom politicians are particularly concerned. In 2014, there were 219.9 million eligible voters in the United States, out of which 44.1 million, or 20%, were sixty-five and older.²¹² Among seniors, 59.4% voted in the 2014 midterm elections, compared to 49.% in the 45–64 age group, 37.8% in the 35–44 age group, and 23.1% in the 18–34 age group.²¹³

One would think that elder matters would be high on the political agenda and that politicians would rush to offer and provide seniors with generous benefits. Yet, the concerns of the elderly are hardly foremost on voters' and legislators' minds. A Kaiser Health Tracking Poll conducted in January 2016 identified the ten issues that most concerned voters in 2016. In their order of importance to voters they were: terrorism, the economy and jobs, cost of health care and health insurance, dissatisfaction with the government, the federal budget deficit, gun control, the situation in Iraq and Syria, the 2010 Health Care law, immigration, taxes, race relations, and climate change.²¹⁴ Even though the dearth of support for the elderly and their caregivers will affect almost all Americans, it was not recognized as a top ten issue by voters. As noted in a FrameWorks Institute report, “[o]lder adults have an enormous economic and social impact on American society – an impact that

210. U.N. Human Rights Office of the High Commissioner, United Nations Principles for Older Persons, G.A. Res. 46/91, Annex, U.N. Doc. A/RES/46/91/Annex (Dec. 16, 1991), <http://www.ohchr.org/EN/ProfessionalInterest/Pages/OlderPersons.aspx>.

211. Fredvang & Biggs, *supra* note 204, at 14–18; Miller, *supra* note 207, at 364.

212. Thom File, *WHO VOTES? CONGRESSIONAL ELECTIONS AND THE AMERICAN ELECTORATE: 1978–2014* 2, 2–3 U.S. CENSUS BUREAU, POPULATION CHARACTERISTICS, P20-577 (2015), <https://www.census.gov/content/dam/Census/library/publications/2015/demo/p20-577.pdf>.

213. *Id.* at 5–6.

214. Bianca DiJulio et al., *Kaiser Health Tracking Poll: January 2016* 1, KAISER FAMILY FOUND. 1, 4–5 (Jan. 28, 2016), <http://kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-january-2016/> [hereinafter DiJulio et al.].

is often not well accounted for in our discourse, media and public policy.”²¹⁵

This Part first explores public choice theory as a partial explanation for why elder matters are not high on the list of priorities for either voters or politicians. It argues that politicians may not perceive promoting the welfare of the elderly as having sufficient pay-offs. It also examines the efficacy of advocacy groups such as the AARP. Next, this Part argues that both policymakers and voters neglect aging matters because they are unwilling to contemplate the prospect of their own decline. Finally, this Part examines the media’s role in agenda-setting and their limited interest in aging issues.

A. Public Choice Theory

Public choice theory is an economic theory used to explain the behavior of political actors. Its essential principles and application to elder matters are discussed below.

1. PRINCIPLES OF PUBLIC CHOICE THEORY

Public choice theory is a well-regarded economic theory that posits that political actors, including legislators, are primarily motivated by their own self-interest.²¹⁶ Accordingly, legislators have an incentive to provide benefits to voters in their districts or states in order to secure their votes.²¹⁷ For example, legislators might pursue expensive and inefficient “pork barrel” projects, such as non-essential local infrastructure improvements, even though money could be better spent elsewhere.²¹⁸

A typical behavior in which legislators engage is called “logrolling.”²¹⁹ Logrolling is vote trading whereby legislator A promises to vote

215. Eric Lindland et al., *Gauging Aging: Mapping the Gaps Between Expert and Public Understandings of Aging in America*, FRAMEWORKS INST. 5 (2015), http://www.giaging.org/documents/150501_gauging_aging_final_FrameWorks_report.pdf.

216. James B. Kau & Paul H. Rubin, *Self-Interest, Ideology, and Logrolling in Congressional Voting*, 22 J. L. & ECON. 365, 366 (1979) [hereinafter Kau & Rubin]; William F. Shughart II, *Public Choice*, in THE CONCISE ENCYCLOPEDIA OF ECONOMICS (2d ed. 2008), <http://www.econlib.org/library/Enc/PublicChoice.html> [hereinafter Shughart].

217. Robert D. Tollison, *Public Choice and Legislation*, 74 VA. L. REV. 339, 355 (1988) [hereinafter Tollison].

218. *Id.*

219. Kau & Rubin, *supra* note 216, at 366; Tollison, *supra* note 217, at 354–55, MAXWELL L. STEARNS & TODD J. ZYWICKI, PUBLIC CHOICE CONCEPTS AND

for legislator B's pet project in return for B's vote for A's project of choice.²²⁰ The constituents of both legislators will be pleased by the benefits of the pet projects even if these are objectively wasteful and irresponsible, and both legislators will be more optimistic about being re-elected.²²¹

Moreover, legislators tend to respond to organizations representing small groups with homogenous interests whose members have a high stake in policy outcomes and are thus passionate about them.²²² As an example, the farm lobby has succeeded in securing generous government subsidies.²²³ Notably, the extremely powerful National Rifle Association (NRA) has a relatively small membership of five million individuals.²²⁴

By contrast, large groups, such as the elderly population, often have more diverse interests and experience difficulty in organizing to promote a particular cause.²²⁵ In addition, members of large groups may hesitate to do the work of organizing and pursuing initiatives because other members will be able to free-ride and enjoy attained benefits without expending any effort themselves.²²⁶

Public choice theory also teaches that voters behave rationally when they do not invest effort in educating themselves about individual candidates or ballot issues or do not vote at all.²²⁷ The likelihood that a single person's vote will change the outcome of an election is vanishingly small. Thus, from an individual voter's perspective, investing considerable time in obtaining reliable information or even going to the polls at all is not worthwhile.²²⁸ Consequently, voters may not

APPLICATIONS IN L. 26-28 (West Acad. Pub., 1st ed. 2009) [hereinafter STEARNS & ZYWICKI].

220. Kau & Rubin, *supra* note 216, at 366; Tollison, *supra* note 217, at 354-55.

221. *Logrolling*, POL. DICT., <http://politicaldictionary.com/words/logrolling/> (last visited Oct. 15, 2017).

222. Tollison, *supra* note 217, at 342; Shughart, *supra* note 216.

223. Shughart, *supra* note 216.

224. Christopher Ingraham, *Most Gun Owners Don't Belong to the NRA – and They Don't Agree with It Either*, WASH. POST (Oct. 15, 2015), https://www.washingtonpost.com/news/wonk/wp/2015/10/15/most-gun-owners-dont-belong-to-the-nra-and-they-dont-agree-with-it-either/?utm_term=.c580909ce280.

225. Tollison, *supra* note 217, at 342; Shughart, *supra* note 216.

226. Tollison, *supra* note 217, at 342; Shughart, *supra* note 216; STEARNS & ZYWICKI, *supra* note 219, at 14-15.

227. Tollison, *supra* note 217, at 363; Shughart, *supra* note 216.

228. Shughart, *supra* note 216.

dedicate themselves to learning which candidates are more likely to advocate for issues that are important to them and which candidates will improve their welfare.

2. APPLYING PUBLIC CHOICE THEORY TO ADVOCACY FOR THE ELDERLY

At first glance, public choice theory suggests that both policymakers and voters should prioritize support for the elderly out of self-interest. Everyone hopes for longevity and a good quality of life in later years, which means everyone should hope for plentiful and affordable long-term care, transportation, geriatric care, and other benefits. Moreover, many if not most adults will have elderly loved ones that require care, and the responsibilities of care-giving can be overwhelming without adequate support services.²²⁹

At the same time, however, public choice theory may partially explain why elder matters are not more of a legislative priority. Legislators likely do not perceive advocacy for the elderly as sufficiently promoting their own best interests. Senior citizens consist of tens of millions of individuals,²³⁰ spread across the country, with diverse political views and interests. Therefore, they are not the type of small, homogenous interest group towards which politicians naturally gravitate.²³¹ Politicians may not believe that if they fight to pass a particular measure that benefits the elderly, they will, in return, secure the votes of most seniors in their district or state. Instead, seniors are likely to care more about other issues (e.g. terrorism or the deficit)²³² and to vote based on the candidates' positions on those matters or based on their party affiliation. Public choice theory also suggests that many voters will not study the complexities of elder issues and investigate candidates' positions regarding these matters. Doing so can be considered an inefficient use of time because a single individual's vote has only a minute impact on election outcomes.

In fact, politicians may believe that advocacy for the elderly can backfire. Effectively tackling the challenges that this population faces will require considerable monetary investments. Increasing funding for OAA programs, making quality long-term care affordable, attracting

229. See A. Hoffman, *supra* note 38, at 186, 188, 191 (stating that "even if people take on caring for another with great generosity and love, long-term care is extremely demanding. Even in the best of circumstances, it will take a toll.").

230. See U.S. Census Bureau, *supra* note 1 and accompanying text.

231. See Kau & Rubin, *supra* note 216, at 342.

232. DiJulio et al., *supra* note 214.

clinicians to the field of geriatrics, and even developing appropriate mechanisms to identify at-risk drivers are all far from inexpensive propositions.²³³ Recall that the CLASS Act, which had been passed as part of the Affordable Care Act in order to help Americans obtain long-term care insurance, had to be abandoned for financial reasons.²³⁴ Politicians who support such initiatives in the current political climate may suffer relentless criticism for being fiscally irresponsible “tax and spend” advocates.

3. THE AARP AND OTHER ADVOCACY ORGANIZATIONS

Public choice theory suggests that the elderly should nevertheless have significant influence because they are represented by strong advocacy organizations, chief among them is the AARP.²³⁵ The AARP is consistently listed among the top ten lobbyists in the United States.²³⁶

The AARP has an ambitious “Priorities Book” that covers a large number of issues.²³⁷ Recently, it has been very active in supporting caregivers, helping over thirty states pass the Caregiver, Advise, Record and Enable (CARE) Act.²³⁸ This statute requires hospitals and rehabilitation facilities to do the following:

- Record the name of the family caregiver at the time an individual is admitted to the hospital;
- Provide family caregivers with adequate notice prior to hospital discharge; and

233. See *supra* Part II.

234. See CLASS, *supra* note 136; Kyle, *supra* note 137; Letter from Secretary, *supra* note 138.

235. See Kau & Rubin, *supra* note 216; AM. ASS’N OF RETIRED PERSONS, AARP, <http://www.aarp.org/> (last visited Sept. 25, 2017).

236. Michelle Leach, *10 Most Powerful Special Interest Groups in America*, Listosaur.com (July 2, 2014), <http://listosaur.com/politics/10-powerful-special-interest-groups-america/> (listing AARP as the fourth most powerful interest group); Gerri Hastley, *10 of the Biggest Lobbies in Washington*, BUSINESS PUNDIT (Apr. 26, 2011, 12:06 PM), <http://www.businesspundit.com/10-of-the-biggest-lobbies-in-washington/>.

237. AARP, THE PRIORITIES BOOK: BUILDING A BETTER FUTURE 2015–2016 6 (2015), http://www.aarp.org/content/dam/aarp/about_aarp/aarp_policies/2015-05/AARP-Priorities-Book-2015-2016.pdf.

238. Elaine Ryan, *The CARE Act: Helping Family Caregivers from Hospital to Home*, AARP BLOG (March 7, 2016), <http://blog.aarp.org/2016/03/07/the-care-act-helping-family-caregivers-from-hospital-to-home/> [hereinafter Ryan]; AARP, *The Caregiver, Advise, Record, Enable (CARE) Act* (updated April 4, 2017), <http://www.aarp.org/content/dam/aarp/home-and-family/caregiving/2017/05/care-act-map-2017-aarp.pdf>; see e.g., CAL. HEALTH & SAFETY CODE §1262.5 (2016); 210 ILL. COMP. STAT. §§ 91/1-91/99 (2016).

- Provide family caregivers with clear, in-person instructions regarding medical tasks they will need to perform when their loved one returns home.²³⁹

Among other initiatives, the AARP has also lobbied Congress to pass the Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Act and the Credit for Caring Act and to strengthen Social Security.²⁴⁰ The AARP is also well known for having provided an important endorsement for the ACA in 2009.²⁴¹

However, it would be no surprise to public choice theorists that the AARP itself acts in its own best interest. For example, it has been accused of supporting Obamacare cuts to Medicare because the organization's health insurance arm would profit from them.²⁴² The AARP sells private Medigap policies to consumers who want health insurance that supplements the limited payments they get from Medicare.²⁴³ Consequently, the AARP has much to gain from Medicare cuts that will encourage more people to purchase its insurance products. It may thus act against the interests of the seniors it represents when its own profitability is at stake.

239. Ryan, *supra* note 238; see e.g., CAL. HEALTH & SAFETY CODE §1262.5 (2016); 210 ILL. COMP. STAT. §§ 91/1-91/99 (2016); Larry Schumacher, *How the CARE Act Would Help Family Caregivers*, FORBES (May 1, 2014), <http://www.forbes.com/sites/nextavenue/2014/05/01/how-the-care-act-would-help-family-caregivers/#3e48148b2860> [hereinafter Schumacher].

240. *AARP Volunteers from Every State Head to Capitol Hill to Push Robust Agenda on Family Caregiving, Social Security*, AM. ASS'N OF RETIRED PERSONS (June 8, 2016), <http://www.aarp.org/about-aarp/press-center/info-06-2016/aarp-volunteers-capitol-hill-push-caregiving-social-security.html> (providing that the RAISE Family Caregivers Act would "require the development of a national strategy to support family caregivers," while the Credit for Caring Act would "provide a federal tax credit for eligible working family caregivers").

241. Barry Rand, *AARP Endorses Affordable Health Care for America Act* AARP (Nov. 5, 2009), http://www.aarp.org/about-aarp/press-center/info-11-2009/affordable_health_care_act_endorsement.html.

242. Avik Roy, *How the AARP Made \$2.8 Billion by Supporting Obamacare's Cuts to Medicare*, FORBES (Sept. 22, 2012, 12:13 AM), <http://www.forbes.com/sites/aroy/2012/09/22/the-aarps-2-8-billion-reasons-for-supporting-obama-cares-cuts-to-medicare/#5590a2f14353> [hereinafter Roy]; David Silva, *AARP - Senior Supporter or Scammer?*, LIFE AFTER 50 (Mar. 10, 2012, 4:58 PM), <http://lifeafter50.com/news/2012/mar/10/aarp-senior-supporter-or-scammer/> (stating that the AARP's critics assert that it has "lost its way and became overly partisan and entirely too focused on making money").

243. Roy, *supra* note 242.

In addition, the AARP is often viewed as partisan and inclined towards Democrats.²⁴⁴ In response, several competing, more conservative organizations have been established.²⁴⁵ These include the American Seniors Association,²⁴⁶ the Association of Mature American Citizens,²⁴⁷ and the 60 Plus Association.²⁴⁸

With so many advocacy organizations representing them, one might wonder why more progress has not been made towards promoting the interests of elderly Americans. Progress is slow in part because the AARP and other advocacy organizations can pursue only a few initiatives at a time. Legislators are understandably most responsive to pressure for low-cost interventions such as the CARE Act.²⁴⁹ Yet, the needs of the elderly are wide-ranging and multi-faceted, and addressing them would require very significant investments of effort and money.²⁵⁰ By contrast, the NRA has a simple, coherent, and inexpensive message: opposition to gun control measures and promotion of gun rights.²⁵¹ It is no wonder that many consider the NRA to be the most powerful lobbying organization in America.²⁵²

Furthermore, if politicians who belong to one party perceive a special interest organization as being partisan and sympathetic to a different party, they may not be receptive to its overtures because they do not believe that its members will vote for them. Putting aside party affiliation, the AARP and its competitors may not easily convince politicians that they can secure votes for them. Many seniors care more deeply about other issues and may not even be aware of advocacy efforts on their behalf.²⁵³ Thus, candidates' views concerning benefits for

244. Diane C. Lade, *Anti-AARP Groups Looking to Woo New Retirees*, SUN SENTINEL (Jan. 14, 2013), http://articles.sun-sentinel.com/2013-01-14/about/fl-conservative-aarp-alternatives-20130113_1_anti-aarp-groups-south-floridians.

245. *Id.*

246. AM. SENIORS ASS'N, <https://www.americanseniors.org/> (last visited Sept. 25, 2017) (characterizing itself as "the conservative alternative to AARP").

247. *About Us: Overview*, ASS'N OF MATURE AM. CITIZENS, <http://amac.us/about-us/> (last visited Sept. 25, 2017) (noting its "conservative philosophies").

248. *About 60 Plus*, THE 60 PLUS ASS'N, <http://60plus.org/about/> (last visited Sept. 25, 2017) (stating that "60 Plus is often viewed as the conservative alternative to the American Association of Retired Persons (AARP)").

249. See Ryan, *supra* note 238; Schumacher, *supra* note 239.

250. Brian Palmer, *Why is the NRA So Powerful*, SLATE (June 29, 2012), http://www.slate.com/articles/news_and_politics/explainer/2012/06/eric_holder_charged_with_contempt_how_did_the_nra_swing_the_votes_of_so_many_democrats.html (noting that the "AARP . . . attempts to influence such diverse issues as Social Security, health care, energy, and ballot access laws").

251. *Id.*

252. *Id.*

253. See DiJulio et al., *supra* note 214.

the elderly or their caregivers may not be important enough to voters to sway their decisions at the polls.

B. Unwillingness to Contemplate the Prospect of Decline in Old Age

Another possible explanation for the low priority aging receives on political agendas (and in human rights circles) is rooted in psychology. Human beings tend to eschew unpleasant thoughts about their own futures.²⁵⁴ Many individuals simply do not want to think about aging and the challenges they and their families will face.²⁵⁵ Therefore, they do not recognize these as urgent matters and do not seek interventions to address the needs of the older population. Likewise, legislators themselves may not focus on the fact that government interventions to support the elderly are in their personal best interest because they too may be responsible for the care of elderly loved ones and, later, will likely become frail and dependent themselves.

Some individuals feel that thinking about future difficulties will reduce their happiness in the present.²⁵⁶ Others avoid the topic because they feel it is premature or because family members did not suffer a lengthy period of decline before dying.²⁵⁷ Still others shun it because they feel powerless—they do not have the financial or social resources that will likely be necessary to meet their future needs, and thus worrying about or planning for later years is futile.²⁵⁸

Psychologists have observed a phenomenon called “age-group dissociation.”²⁵⁹ In order to enhance their sense of well-being, some older adults choose not to identify with their age group.²⁶⁰ Thus, they distance themselves psychologically from their contemporaries and

254. Catrinel Cracium & Uwe Flick, “I Will Never be the Granny with Rosy Cheeks”: Perceptions of Aging in Precarious and Financially Secure Middle-Aged Germans, 29 J. AGING STUD. 78, 83 (2014) [hereinafter Cracium & Flick].

255. *Id.*

256. Martin Pinguat & Silvia Sörensen, *Factors that Promote and Prevent Preparation for Future Care Needs: Perceptions of Older Canadian, German, and U.S. Women*, 23 HEALTH CARE FOR WOMEN INT’L. 729, 734 (2002).

257. *Id.* at 735.

258. *Id.*

259. David Weiss & Frieder R. Lang, “They” Are Old but “I” Feel Younger: Age-Group Dissociation as a Self-Protective Strategy in Old Age, 27 PSYCH. & AGING 153, 154 (2012) [hereinafter Weiss & Lang].

260. *Id.*

consider themselves to be more similar to younger people than to people their own age.²⁶¹ According to one study, while nearly half of individuals who are fifty or older feel at least ten years younger than they are, a third of those sixty-five or older feel up to nineteen years younger.²⁶²

Indifference towards the challenges of aging may also be attributable to a failure of imagination. People are simply unable to imagine their current selves as frail, older selves.²⁶³ Such a self is “impossible,” too remote and disconnected from one’s existing sense of reality.²⁶⁴ Author and social theorist Simone de Beauvoir wrote that “we have always regarded . . . [old age] as something alien, a foreign species.”²⁶⁵ Thus, human beings often have inflated beliefs about their efficacy, invincibility, and ability to control their destinies.²⁶⁶ According to the American Society on Aging, “67% of Americans don’t believe they will need aging care—ever.”²⁶⁷ In truth, 70% of seniors will require assistance with activities of daily living for an average of three years.²⁶⁸

In fact, most Americans think so little about their own aging that they do not even compose wills.²⁶⁹ More specifically, 51% of those in the age group of fifty-five to sixty-four and 62% of people between the

261. David Weiss & Alexandra M. Freund, *Still Young at Heart: Negative Age-Related Information Motivates Distancing from Same-Aged People*, 27 *PSYCH. & AGING* 173, 174 (2012).

262. Ceridwen Dovey, *What Old Age Is Really Like*, *THE NEW YORKER* (Oct. 1, 2015), <http://www.newyorker.com/culture/cultural-comment/what-old-age-is-really-like>.

263. Laura M. Girling & Leslie A. Morgan, *Older Women Discuss Planning for Future Care Needs: An Explanatory Framework*, 26 *J. AGING & HEALTH* 724, 740 (2014); Tom de Castella & Virginia Brown, *Why Can’t We Imagine Ourselves Getting Old?*, *BBC NEWS MAG.* (Aug. 5, 2011), <http://www.bbc.com/news/magazine-14412025>.

264. Kathryn B. McGrew, *Impossible Selves? Challenges and Strategies for Encouraging Individual Long-Term Care Planning*, *SCRIPPS GERONTOLOGY CTR. PUB.* 1, 7 (2000), <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.549.4139&rep=rep1&type=pdf>.

265. SIMONE DE BEAUVOIR, *THE COMING OF AGE* 283 (W. W. Norton & Co. 1996).

266. *Id.* at 284.

267. Carol Marak, *The Challenges of the Aging Industry*, *AMERICAN SOC’Y ON AGING* (Aug. 13, 2015), <http://www.asaging.org/blog/challenges-aging-industry>.

268. Goldman & Wolf, *supra* note 59, at 13.

269. Richard Eisenberg, *Americans’ Ostrich Approach to Estate Planning*, *FORBES*, Apr. 9, 2014, <http://www.forbes.com/sites/nextavenue/2014/04/09/americans-ostrich-approach-to-estate-planning/#6d26386f07b6>; see also BOARD OF GOVERNORS OF THE FED. RES., *INSIGHTS INTO THE FINANCIAL EXPERIENCES OF OLDER ADULTS: A FORUM BRIEFING PAPER* 21 (2013), <http://www.federalreserve.gov/newsevents/conferences/older-adults-forum-paper-20130717.pdf> (stating that only forty-three percent of adults in their forties have prepared wills, and even among individuals seventy and older, only seventy-eight percent have wills).

ages of forty-five and fifty-four have not prepared wills.²⁷⁰ In addition, only about one-quarter to one-third of adults have completed another critical document: an advance directive.²⁷¹ In advance directives, individuals provide instructions for end-of-life care and appoint decision-makers who can direct their care if they lose the ability to make decisions for themselves.²⁷² While many organizations have undertaken educational initiatives regarding these important documents,²⁷³ they have failed to gain adequate traction.

People who are middle-aged and older who reject thoughts of aging, fail to plan for it, and do not make use of easily available legal protections, are unlikely to become advocates for the elderly. They are unlikely to contact legislators and seek government intervention that could improve their quality of life in the future.

C. The Media's Role in Agenda Setting

The media's treatment of the elderly may further contribute to their relative neglect in the policy arena. The media can tell compelling stories and can launch sustained efforts to educate the public about important social problems. Consequently, the media could potentially convince voters that addressing the needs of the elderly is in their own best interest and persuade politicians that they would be richly rewarded for efforts to improve the lives of older Americans. Yet, the media expend little energy on creating political momentum for change in this area.²⁷⁴

270. *Id.*

271. Jaya K. Rao et al., *Completion of Advance Directives Among U.S. Consumers*, 46 AM. J. PREV. MED. 65, 65 (2014) (finding that of 7946 respondents to a survey, 26.3% had an advance directive); Keshia M. Pollack et al., *The Public's Perspectives on Advance Directives: Implications for State Legislative and Regulatory Policy*, 96 HEALTH POLICY 57, 57 (2010) (finding that "[a]pproximately 34% (n=401) of Maryland adults reported having" an advance directive).

272. S. HOFFMAN, *supra* note 6, at 41-48; Diana Anderson, *Review of Advance Health Care Directive Laws in the United States, the Portability of Documents, and the Surrogate Decision Maker when No Document Is Executed*, 8 NAT'L ACAD. ELDER L. ATT'YS J. 183, 183 (2012).

273. See e.g., *Put It in Writing*, AM. HOSP. ASS'N, <http://www.aha.org/advocacy-issues/initiatives/piiw/index.shtml> (last visited Sept. 25, 2017).

274. See generally Moira O'Neill & Abigail Haydon, *Aging, Agency, and Attribution of Responsibility: Shifting Public Discourse about Older Adults*, FRAMEWORKS INST. (2015), http://www.frameworksinstitute.org/assets/files/aging_ffa_final_090215.pdf.

A 2015 study by the FrameWorks Institute found that “the public is exposed to bits and pieces of narrative—fractured, and often inconsistent, information about aging and older adults—and that this array of information is unlikely to stick in mind and, thus, is unlikely to deepen public understandings of aging issues.”²⁷⁵ When the media do turn their attention to the elderly, they tend to tell isolated, problem-oriented stories that focus on the travails of individuals.²⁷⁶ News pieces generally do not analyze policy failures that are at the root of problems and do not provoke viewers to think deeply about their possible solutions.²⁷⁷ Instead, media stories often suggest that successful aging is attributable to individual lifestyle choices and is entirely divorced from public policies, social determinants, and societal support mechanisms.²⁷⁸

Several research projects have focused on the media’s agenda-setting powers and questioned the degree of their influence. One study found that the “media can only impact the political agenda when all forms of media focus on the same issue, frame it the same way, and are persistent with their coverage of the issue.”²⁷⁹ The researchers concluded that such convergence is rare.²⁸⁰

According to the same study, the media have little to no power to set candidates’ agendas during election campaigns.²⁸¹ At other times, politicians are most responsive to stories about newer issues rather than coverage of long-standing and intractable problems.²⁸²

A second study noted that the media choose to cover stories that are novel and feature conflict and drama rather than basing their selections on the importance of the subject matter.²⁸³ The public, therefore, should not invest “gatekeeping trust” in the media, that is, trust that

275. *Id.* at 3, 5. The report is part of a project sponsored by prominent organizations including the AARP, the American Federation for Aging Research, the American Geriatrics Society, the American Society on Aging, the Gerontological Society of America, the National Council on Aging, and the National Hispanic Council on Aging.

276. *Id.* at 5–6.

277. *Id.*

278. *Id.* at 6.

279. Stefaan Walgrave & Peter Van Aelst, *The Contingency of the Mass Media’s Political Agenda Setting Power: Toward a Preliminary Theory*, 56 J. COMM. 88, 93 (2006).

280. *Id.*

281. *Id.* at 96.

282. *Id.* at 93–94.

283. Raymond J. Pingree et al., *Effects of Media Criticism on Gatekeeping Trust and Implications for Agenda Setting*, 63 J. COMM. 351, 351 (2013).

the media are highlighting the social policy issues of greatest significance.²⁸⁴

The media could play a role in convincing both voters and politicians that focusing on the needs of the elderly would advance their own interests.²⁸⁵ However, like all other stakeholders, the media act out of self-interest and apparently do not believe that playing such a role would further their own economic goals of selling their products, selling advertising spots, and earning high ratings.²⁸⁶

The problems that the elderly face are deep-rooted and are not as exciting as newly emerging crises.²⁸⁷ To the extent that the media present stories about the elderly, they tend to be “sensational” and emphasize drama and individual struggle rather than critical thinking about the underlying causes of the challenges that the elderly face and potential solutions.²⁸⁸

Furthermore, advertisers seek to target young consumers who are more easily influenced by marketing initiatives and who make more purchases than older individuals.²⁸⁹ In particular, they value female readers and viewers in the eighteen to thirty-four age group.²⁹⁰ Consequently, in order to appeal to advertisers, media outlets may tailor their

284. *Id.* at 369.

285. Robert J. Brulle et al., *Shifting Public Opinion on Climate Change: An Empirical Assessment of Factors Influencing Concern Over Climate Change in the U.S., 2002-2010*, 114 *CLIMATE CHANGE* 169, 175 (2012) (discussing the ideas that “public opinion is a reflection of the extent and prominence of media coverage” and that “the major impact of news media coverage is heightened issue salience”).

286. Tai-Li Wang, *Presentation and Impact of Market-Driven Journalism on Sensationalism in Global TV News*, 74 *INT’L COMMUN. GAZETTE* 711, 712 (2012) (stating that “[m]arket-driven forces are speculated to be the primary causes behind the spike in sensationalism”) [hereinafter Wang].

287. See Weiss & Lang, *supra* note 259.

288. See Cracium & Flick *supra* note 254; see also Wang, *supra* note 286, at 714 (stating that “sensational news stories focus on private citizens or celebrities to personalize or dramatize news stories, rather than allowing officials or more authoritative sources to legitimate the stories”); Monika Djerf-Pierre, *The Crowding-Out Effect: Issue Dynamics and Attention to Environmental Issues in Television News Reporting Over 30 Years*, 13 *JOURNALISM STUD.* 499, 503 (2012) (finding that the media pay more attention to “obtrusive” issues—those that have an immediate impact on everyday lives, such as energy price, employment levels, and inflation rather than “unobtrusive” issues such as environmental problems that are distant in time and deal with “ambiguous processes, complex causes and effects, uncertainty, and future risks”).

289. JAMES T. HAMILTON, *ALL THE NEWS THAT’S FIT TO SELL: HOW THE MARKET TRANSFORMS INFORMATION INTO NEWS* 71 (2004) [hereinafter HAMILTON]; *Our Understanding of the Older Consumer*, *COMING OF AGE*, <http://www.comingofage.com/what-weve-learned-2/> (last visited Sept. 25, 2017) (stating that “[a]dult consumers tend to be less responsive to sweeping claims in marketing messages as they age”).

290. HAMILTON, *supra* note 289, at 71.

programming to younger audiences and neglect stories that are relevant primarily to older people.²⁹¹ Indeed, younger people are particularly attentive to “breaking news,”²⁹² which encourages the media’s tendency to cover dramatic stories of immediate import. Thus, media coverage represents another missed opportunity to confront and remedy aging-related policy shortcomings.

IV. RECOMMENDATIONS

We do not want to think about getting older, but we must. If American society does not prepare for the tens of millions of baby boomers who will become elderly in the coming years, the consequences will be grave in terms of suffering, costs, and lives lost. The overarching recommendation of this Article, therefore, is that American society stop ignoring the looming challenges of our aging population and tackle them with energy and commitment.

Formulating a comprehensive blueprint for solving the many difficulties that seniors face in the United States is well beyond the scope of this Article. Such a plan could fill many volumes. Instead, we briefly review the work of other policy experts and outline a number of interventions that would address the specific problems that this Article highlights.

A. Existing Reports and Initiatives

The Milbank Memorial Fund issued a report in 2016 that offered a long list of activities that policy makers should consider in order to advance the following eight general goals:

- support age-friendly communities;
- meet the housing and transportation needs of seniors;
- increase the financial security and reduce financial exploitation of older adults;
- improve long-term services and support;
- implement caregiver-friendly policies;

291. *Id.* at 101 (stating that “[a]n increase in one percentage point of women 18-34 listing the issue as a top priority translates into 1.28 more stories about the issue on the evening news broadcast”).

292. AM. PRESS INST., *Social and Demographic Differences in News Habits and Attitudes* (Mar. 17, 2014, 3:00 PM), <https://www.americanpressinstitute.org/publications/reports/survey-research/social-demographic-differences-news-habits-attitudes/>.

- improve recruitment and retention of the long-term care workforce;
- assist adults with dementia; and
- advance telehealth.²⁹³

Representative Debbie Dingell emphasizes the need to support family caregivers, shift Medicaid's focus away from nursing homes to settings that the elderly prefer, improve Medicare in a variety of ways, and initiate a national conversation about financing long-term care.²⁹⁴ A third source, the Long-Term Care Financing Collaborative, issued a consensus framework in 2016 with the following primary recommendations:

- Creation of a universal catastrophic insurance program to provide support to individuals with high care needs over a significant period of time;
- Public and private sector initiatives and policies to improve the long-term care insurance market along with efforts to encourage saving for retirement;
- Modernization of the Medicaid long-term care safety net for economically disadvantaged individuals with more flexibility as to care setting; and
- Strengthening support for the families and communities of individuals obtaining care at home.²⁹⁵

Likewise, the National Council on Aging (NCA) states that it "is working to promote a bipartisan, national long-term care insurance financing system" that:

- Is actuarially sound
- Is fully paid for
- Increases affordable options for working Americans
- Does not exclude purchasers based on pre-existing health conditions
- Improves market opportunities for private insurance
- Produces significant savings to Medicaid.²⁹⁶

293. GOLDMAN & WOLF, *supra* note 59, at 7-27.

294. Dingell, *supra* note 24, at 321-24.

295. *A Consensus Framework for Long-Term Care Financing Reform*, LONG-TERM CARE FINANCING COLLABORATIVE (2016), <http://www.convergencepolicy.org/wp-content/uploads/2016/02/LTCFC-FINAL-REPORT-Feb-2016.pdf>.

296. *Long-Term Care Financing*, NAT'L COUNCIL ON AGING, <https://www.ncoa.org/public-policy-action/long-term-services-and-supports/long-term-care-financing/> (last visited Sept. 25, 2017) (stating that several organizations have developed proposals to finance long-term care including the Bipartisan Policy Center, Long-Term Care Financing Collaborative, LeadingAge, Urban Institute, and Leadership Council of Aging Organizations and Consortium for Citizens with Disabilities).

B. Specific Interventions

Policy papers and reports are important, but they are not enough. The time has come to meet the needs of our growing elderly population with action. Below are examples of legal and other interventions that address some of the challenges analyzed in this Article.

1. LONG-TERM CARE

Policymakers will not be able to remedy the shortcomings of long-term care in the United States without investing considerable financial resources. This is perhaps the most significant problem that the elderly face, but extensive government intervention in this area is unlikely in the current, fiscally conservative climate. Nevertheless, it is worth mentioning that more generous Medicare reimbursement and liberalized Medicaid eligibility criteria would be important improvements. Furthermore, Congress should renew efforts to pass legislation such as the defunct CLASS Act²⁹⁷ to make long-term care insurance affordable and useful for many more Americans.

Efforts must also be made to increase the job satisfaction and retention of professional caregivers.²⁹⁸ Wage increases, health benefits, paid sick days, and policies that promote full-time (rather than part-time) work and job security would all ameliorate caregivers' stress and anxiety.²⁹⁹ For example, a California study showed that nearly doubling the wages of home care workers increased the retention rate from 39% to 74%.³⁰⁰

2. DRIVING

To address driving concerns, states should conduct further research to determine which interventions are effective and implement additional regulations to protect elderly drivers and those who share the roads with them.³⁰¹ In 2014, Canada's Ministry of Transportation

297. See CLASS, *supra* note 136.

298. See *supra* Part II.B.3.

299. Linda Delp et al., *Job Stress and Job Satisfaction: Home Care Workers in a Consumer-Directed Model of Care*, 45 HEALTH SERV. RES. 922, 933-34 (2010); Peter Kemper et al., *What Do Direct Care Workers Say Would Improve Their Jobs? Differences across Settings*, 48 GERONTOLOGIST (suppl_1), 17, 17 (2008) (noting that "workers called for more pay and better work relationships including communication; supervision; and being appreciated, listened to, and treated with respect").

300. *Shortage of Aides*, *supra* note 141.

301. Owsley & McGwin Jr., *supra* note 178, at 2357.

undertook a new initiative in Ontario, requiring the following of drivers eighty and older: 1) a vision test; 2) attendance in educational classes; 3) a review of the driver's record; and 4) two exercises consisting of drawing the hands of a clock to 11:10 and crossing out the "H" in rows of letters.³⁰² Data from this and other pilot projects may be illuminating for U.S. policy makers. It is also noteworthy that more onerous state licensing requirements, regardless of their specifics, can in and of themselves induce drivers to decrease or stop driving of their own accord.³⁰³ Likewise, investment in both innovative car safety technology (e.g. rear-view cameras and warning alarms) and alternative transportation options (e.g. public buses and volunteer driver programs)³⁰⁴ is necessary to reduce the likelihood that seniors lose their independence because of impairments that impact driving ability.³⁰⁵

3. GERIATRIC CARE

What can be done to make geriatrics more attractive to American health care providers? A variety of interventions can be employed for this purpose. More generous Medicare reimbursement for geriatric services would be of obvious benefit. Various payment enhancements have been implemented for other purposes in the past. For example, the ACA established a four-year program through which primary care physicians could receive a 10% bonus for seeing Medicare patients, but the program expired in 2015.³⁰⁶ Currently, the Centers for Medicare & Medicaid Services (CMS) offers 10% bonuses to physicians who pro-

302. Lorraine Sommerfeld, *Drive, She Said: New Test Coming Soon for Elderly Ontario Drivers*, GLOBE AND MAIL (Jan. 31, 2014), <http://www.theglobeandmail.com/globe-drive/news/new-test-coming-soon-for-elderly-ontario-drivers/article16638607/>.

303. Elena Kulikov, *The Social and Policy Predictors of Driving Mobility Among Older Adults*, 23 J. AGING & SOC. POL'Y 14 (2011).

304. Ken Teegardin, *Personal Transportation for Seniors*, SENIORLIVING.ORG, <http://www.seniorliving.org/lifestyles/personal-transportation/> (last updated Sept. 12, 2011).

305. Dave Bernard, *New Car Features Help Seniors Drive Safely*, U.S. NEWS & WORLD REP. (Feb. 1, 2013), <http://money.usnews.com/money/blogs/on-retirement/2013/02/01/new-car-features-help-seniors-drive-safely>; S. HOFFMAN, *supra* note 6, at 65-67.

306. *Primary Care Incentive Payment Program (PCIP) Eligibility for New Providers Enrolled in Medicare*, U.S. DEP'T OF HEALTH AND HUMAN SERVS. (DHHS) & CTRS. FOR MEDICARE & MEDICAID SERVS. (CMS) (Feb. 11, 2011), <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2152CP.pdf>; Michelle Andrews, *End of Medicare Bonuses Will Cut Pay to Primary Care Doctors*, NPR (Nov. 28, 2015), <http://www.npr.org/sections/health-shots/2015/11/28/457148697/end-of-medicare-bonuses-will-cut-pay-to-primary-care-doctors>.

vide Medicare-covered services to patients in geographic “health professional shortage areas,” as designated by the Health Resources and Services Administration.³⁰⁷ Similar supplements could be created to boost the earnings of geriatricians across the United States.

Many state and federal programs offer loan forgiveness and scholarship opportunities to medical students and clinicians who meet particular requirements.³⁰⁸ Such programs could be used to incentivize individuals to pursue geriatric training.³⁰⁹ Educational and licensing authorities should also take action. They must incorporate more extensive requirements for education about elder care in medical school curricula and for licensure and certification purposes.³¹⁰

Not all legislators ignore the need for change. Representative Joseph Crowley (D-NY) has repeatedly introduced a congressional bill, the “Resident Physician Shortage Reduction Act,” to increase the number of residency slots by 15,000 over five years, with many slots dedicated to specialties in which shortages exist.³¹¹ The bill, however, has never been enacted.

C. Solutions Based on Public-Choice Theory

Public choice theory teaches that legislators and regulators will become interested in finding solutions to problems that plague the elderly if concerned stakeholders pressure them to do so and convince them that they will gain political pay-offs. To that end, advocates must undertake vigorous public education campaigns to convince the public,

307. CTRS. FOR MEDICARE & MEDICAID SERVS., *Health Professional Shortage Area Physician Bonus Program 2* (Jan. 2016), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HPSA_fchtsht.pdf.

308. ASS'N OF AM. MED. COLL., *Loan Repayment/Forgiveness and Scholarship Programs*, https://services.aamc.org/fed_loan_pub/index.cfm?fuseaction=public.welcome&CFID=1&CFTOKEN=C0F700B0-C188-2D46-DBD89B242E4967FD (last visited, Sept. 25, 2017); U.S. DEP'T OF HEALTH AND HUMAN SERVS., *National Health Service Corps: Loan Repayment*, <http://nhsc.hrsa.gov/loanrepayment/> (last visited Sept. 25, 2017).

309. Seegert, *supra* note 202.

310. *Id.*; Sadick, *supra* note 195; INST. OF MEDICINE, *RETOOLING FOR AN AGING AMERICA: BUILDING THE HEALTH CARE WORKFORCE 123-183* (2008); Olivero, *supra* note 192.

311. See e.g. H.R.1180, 113th Cong. (1st Sess. 2013); H. R. 2124, 114th Cong., (1st Sess. 2015); *4 Things Students Should Know about the New GME Bill*, AMA WIRE (May 20, 2015), <http://www.ama-assn.org/ama/ama-wire/post/4-things-students-should-new-gme-bill>.

government officials, and the media that the challenges the elderly face are a serious and personal concern for all.

As noted earlier, voters list terrorism as their first and most serious national concern.³¹² In truth, however, terrorism directly affects very, very few individuals.³¹³ Only eighty Americans were killed in terrorist attacks between 2004 and 2013, and of those, only thirty-six were murdered on U.S. soil.³¹⁴ In the words of one scholar, in the post-9/11 world, even courts are “likely to overstate the potential harm, neglect the probability, and presume the imminence of terrorist attacks.”³¹⁵ By contrast, eldercare problems are likely to affect nearly all Americans.

Advocacy organization such as the AARP and senior centers could produce educational materials about elder matters, including widely distributed informational brochures, media programs, and community events. According to the National Council on Aging, 11,400 senior centers exist across the country, offering a wide range of programs and services, and over one million participants visit them every day.³¹⁶

In addition, enterprising activists can initiate public engagement campaigns at the grass roots level. A movement called *The Conversation Project* promotes discussion of end-of-life care preferences among loved ones in small social gatherings and provides “conversation starter kits.”³¹⁷ A second, similar initiative, *Death over Dinner*, encourages families and close friends to dine together and discuss death and dying matters.³¹⁸ Between 2013 and mid-2016, the organization inspired people to hold over 100,000 dinners in thirty countries.³¹⁹ These programs

312. DiJulio, *supra* note 214.

313. Dave Mosher and Skye Gould, *How Likely are Foreign Terrorists to Kill Americans? The Odds May Surprise You*, BUS. INSIDER (Jan. 31, 2012).

314. *American Deaths in Terrorist Attacks*, Nat'l Consortium for the Study of Terrorism and Responses to Terrorism (Oct. 2015), https://www.start.umd.edu/pubs/START_AmericanTerrorismDeaths_FactSheet_Oct2015.pdf.

315. Avidan Y. Cover, *Presumed Imminence: Judicial Risk Assessment in the Post-9/11 World*, 35 CARDOZO L. REV. 1415, 1415 (2014).

316. *Senior Center Facts*, NAT'L COUNCIL ON AGING, <https://www.ncoa.org/news/resources-for-reporters/get-the-facts/senior-center-facts/> (last visited Sept. 25, 2017).

317. *The Conversation Project*, INST. FOR HEALTHCARE IMPROVEMENT, <http://www.ihc.org/engage/initiatives/ConversationProject/Pages/default.aspx> (last visited Sept. 25, 2017).

318. *Death over Dinner*, *Let's Have Dinner and Talk about Death*, <http://deathoverdinner.org/> (last visited Sept. 25, 2017).

319. Richard Harris, *Discussing Death over Dinner*, THE ATLANTIC (Apr. 16, 2016), <http://www.theatlantic.com/health/archive/2016/04/discussing-death-over-dinner/478452/>.

or others like them could encourage older adults and their family members to gather and discuss other topics, including long-term-care, driving hazards, and geriatric care and to emphasize the importance of political engagement regarding these issues.

Government agencies can help educate the public as well. The U.S. Department of Health and Human Services includes the Administration on Aging (AoA), which is tasked with administering the Older Americans Act of 1965.³²⁰ As our population ages and its needs intensify, the AoA could be given further responsibilities, including educational functions.

The U.S. Senate has a Special Committee on Aging, which has no legislative authority, but can “study issues, conduct oversight of programs, and investigate reports of fraud and waste.”³²¹ Many state legislatures have similar committees.³²² The existence of these committees indicates that legislatures are aware that there is much to be done to improve the quality of life of American seniors, even if this is not a priority action item for them.

At the time of this writing, shortly after the inauguration of President Trump, an unprecedented number of Americans are participating in political activity, contacting legislators, protesting, and voicing their concern about a variety of policies.³²³ Citizens (and other residents) have proven that when they are unified and committed enough to particular causes, they can be vocal and effective advocates. This same energy should carry over to more entrenched social problems, including elder matters.

320. U.S. DEP'T OF HEALTH AND HUMAN SERVS., ADMIN. ON AGING (AOA), <https://aoa.acl.gov/> (last modified Sept. 21, 2015). For more on the Older Americans Act of 1965, see *supra* Part II.A.

321. U.S. SENATE SPECIAL COMMITTEE ON AGING, *History*, <http://www.aging.senate.gov/about/history> (last visited Sept. 25, 2017).

322. See e.g., Gary Jessee, *Legislative Committee on Aging: Collaborative Aging Services*, TEXAS HEALTH AND HUMAN SERV., <http://www.senate.state.tx.us/75r/senate/commit/c802/c802.htm> (last visited Sept. 25, 2017); CAL. STATE ASSEMBLY COMM. ON AGING AND LONG-TERM CARE, WELCOME TO THE COMMITTEE ON AGING AND LONG-TERM CARE, <http://altc.assembly.ca.gov/> (last visited Sept. 25, 2017); THE 189TH GENERAL COURT OF THE COMMONWEALTH OF MASS., JOINT COMMITTEE ON ELDER AFFAIRS, <https://malegislature.gov/Committees/Joint/J44> (last visited Sept. 25, 2017).

323. Ashley Killough, *Congress Deluged with Phone Calls*, CNN (Feb. 3, 2017), <http://www.cnn.com/2017/02/03/politics/congress-phone-calls/>; Conor Friedersdorf, *The Significance of Millions in the Streets*, THE ATLANTIC (Jan. 23, 2017), <https://www.theatlantic.com/politics/archive/2017/01/the-significance-of-millions-in-the-streets/514091/>.

CONCLUSION

It is not impossible to achieve policy changes. In January 2016, Medicare implemented a change that allows physicians to be reimbursed for discussing end-of-life care with patients.³²⁴ Thus, doctors can now bill Medicare for discussing advance directives with their patients and counseling them about different approaches to end-of-life care, such as aggressive treatment in an intensive care unit versus hospice care.³²⁵ The reimbursement rule was initially part of the ACA but was not implemented because of vigorous opposition from Sarah Palin and others who claimed it would lead to “death panels.”³²⁶ The ACA itself is a law that achieved important and dramatic modifications to the health care system, though its future is now uncertain.³²⁷

Society cannot afford to tolerate a glacial pace of change. The shortcomings and pitfalls of the systems the elderly must navigate are grave and numerous, and they affect a substantial and growing portion of the American population.³²⁸ As the National Council on Aging wrote in a recent issue brief, “[t]he status quo is not sustainable and it is urgent that we better understand and address the problems facing the millions of families struggling daily with these concerns.”³²⁹

The problems with which this Article grapples impact not only the elderly, but also their younger family members who can, at any moment, become caregivers. Thus, even those who are middle-aged and younger will benefit from solutions to the problems of the elderly. For example, with more affordable long-term care or long-term care insurance, the elderly would be less likely to resist getting the help they need from paid caregivers for fear of becoming impoverished.³³⁰ Sons and daughters could rely on states to identify and restrict at-risk motorists

324. Rebecca Dresser, *Medicare and Advance Planning: The Importance of Context*, 46 HASTINGS CNTR. REP. 5, 5 (2016) [hereinafter Dresser]; CTR. FOR MEDICARE AND MEDICAID SERVS., *Frequently Asked Questions about Billing the Physician Fee Schedule for Advance Care Planning Services* (July 14, 2016), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf>.

325. Rich Daly, *Few Physicians Utilize Medicare Advance Care Planning Benefit: Survey*, HEALTHCARE BUS. NEWS (Apr. 15, 2016), <https://www.hfma.org/Content.aspx?id=47774>.

326. Dresser, *supra* note 324, at 5.

327. U.S. DEP'T OF HEALTH AND HUMAN SERVS., *Key Features of the Affordable Care Act by Year*, <http://www.hhs.gov/healthcare/facts-and-features/key-features-of-aca-by-year/index.html#> (last updated Aug. 13, 2017).

328. *See supra* Part II.

329. NAT'L COUNCIL ON AGING, *supra* note 108.

330. *See supra* Part II.B.

rather than intervening themselves and initiating painful and traumatic confrontations about the issue of driving. Likewise, caregivers would less often watch their loved ones suffer from complications that occur because their care is not coordinated by competent geriatricians.

Public choice theory has much to teach about American politics. It is natural for individuals and organizations to prioritize their own interests. But one must have an accurate perception of what those interests are. Older adults should not bury their heads in the sand and refuse to think about the challenges that lie ahead. The same is true for younger people who will soon enough become elderly themselves and may well become caregivers long before that. Politicians should not consider promoting the interests of older adults to be a low-payoff proposition. If nothing else, their personal self-interest dictates that these matters receive significant attention because nobody is immune to the trials of both aging and caregiving. There is no time like the present for all stakeholders to confront the prospect of getting older and take action to help those who come before them and to help themselves.

